Department of Veterans Affairs
Office of Inspector General
Washington, DC 20420

FOREWORD

Our Nation depends on VA to care for the men and women who have sacrificed so much to protect our freedoms. These servicemembers made a commitment to protect this Nation, and VA must continue to honor its commitment to care for these heroes and their dependents in a manner that is as effective and efficient as possible. VA health care and benefits delivery must be provided in a way that meets the needs of today's veterans and veterans from earlier eras. It is vital that VA health care and benefits delivery work in tandem with support services like financial management, procurement, and information management to be capable and useful to the veterans who turn to VA for the benefits they have earned.

Office of Inspector General (OIG) audits, inspections, investigations, and reviews recommend improvements in VA programs and operations, and act to deter criminal activity, waste, fraud, and abuse in order to help VA become the best-managed service delivery organization in Government. Each year, pursuant to Section 3516 of Title 31, United States Code, OIG provides VA with an update summarizing the most serious management and performance challenges identified by OIG work as well as an assessment of VA's progress in addressing those challenges.

This report contains the updated summation of major management challenges organized by the five OIG strategic goals—health care delivery, benefits processing, financial management, procurement practices, and information management—with assessments of VA's progress on implementing OIG recommendations.

OIG will continue to work with VA to address these issues to ensure the best possible service to the Nation's veterans and their dependents.

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Acting Inspector General

Part II. Performance Section

Major Management Priorities and Challenges

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OIG CHALLENGE #1: HEALTH CARE DELIVERY (VHA)
-Strategic Overview-

For many years, the Veterans Health Administration (VHA) has been a national leader in the quality of care provided to patients when compared with other major U.S. health care providers. However, in the Office of Inspector General's (OIG) review of deficiencies in patient scheduling and lengthy waiting times at the Phoenix Health Care System (HCS), OIG also identified nationwide systemic deficiencies of inappropriate and non-compliant scheduling practices that still persist throughout VHA. These problems and the environmental culture that allowed the issues to proliferate negatively impact the quality of care and result in a lack of data integrity. OIG reviews at a growing number of VA medical facilities have provided insight into the current extent of these inappropriate scheduling practices and confirmed that they are systemic throughout VHA.

VHA faces particular challenges in managing access to care, including ensuring the legitimacy of reported waiting times at its health care facilities nationwide. Further, the effectiveness of clinical care, budgeting, planning, and resource allocations are negatively affected due to the continued yearly uncertainty of the number of patients who seek care from VA. Historically, 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 VA Medical Centers (VAMCs) and Community Based Outpatient Clinics (CBOCs) as well as national inspections and audits, issue-specific Hotline reviews, and criminal investigations. This year, OIG used more than half of its workforce to address wait time and inappropriate scheduling allegations. The following sub-challenges highlight the major issues facing VHA today.

OIG Sub-Challenge #1A: Quality of Care (VHA)

VHA provides Veterans with comprehensive primary and specialty medical care; however, VHA continues to face challenges with matching Veterans' demands for specific types of medical care with the appropriate technology, infrastructure, and care providers. This is evident with VHA's difficulty in providing a proper mix of in-house mental health (MH) providers and outpatient MH services as well as integrating purchased care providers seamlessly into the plan of care for Veterans who receive their MH care from non-VA providers. Matching the supply of available providers to the demand for health care is made more difficult by the absence of VHA staffing standards for most physician specialist and MH providers, inaccuracies in data reported from the current appointment and consult management systems, and the lack of oversight to compel VA managers to rigorously evaluate the business case that determines how the provider workforce is utilized.

Modern health care requires that timely decisions be made and then executed with precision. VA is the largest integrated health care organization in the U.S. with a patient electronic health record (EHR) that was originally a model for other health care

organizations. However, VA's EHR has not been upgraded as necessary to keep pace with competing medical record systems with respect to appointment scheduling and decision support. In addition, VAMCs are permitted to modify certain aspects of the EHR, making it difficult and inefficient to implement national system updates and patches and resulting in diversity of nomenclature. VA's EHR has many outstanding features, but without improved standardization and a clear and workable plan going forward, VA will have increasing difficulty managing the data required by providers and administrators to ensure quality and timely health care for Veterans.

While VHA generally provides good quality medical care to its patients, recent OIG work has routinely reported on clinical outcomes or performance where VHA did not meet expectations and where OIG determined there were opportunities by people and systems to prevent untoward outcomes. To strengthen patient confidence and reduce risk of unexpected outcomes, VA managers must focus on operations oversight to ensure that VAMCs operate in accordance with VA and other applicable standards and that health care is VHA's number one priority. A lack of internal oversight and common business rules has resulted in quality of care deficiencies (poor care coordination, delays in diagnosis and treatment, lapses in patient safety, inadequate staff training, and noncompliance with VA policies) that were reported by OIG this past year. These instances include a patient death in an emergency department after safeguards in the EHR were bypassed, inaccuracies in and lack of follow through on root cause analyses, a patient death by overdose and insufficient monitoring in a substance abuse treatment program, a fragmented and inconsistent infection control program that put patients at risk, and concerns regarding operating room cleanliness. To correct these quality care deficiencies, VA must review the current methods used to fill internal vacancies, review quality oversight mechanisms used by Veterans Integrated Service Network (VISN) and national leaders, and make the required changes to address these shortcomings.

Veterans who have been injured during their service often suffer from physical and mental injuries. The use of narcotic medications for pain related symptoms in the U.S. and within VA is of staggering proportions. The use of high doses of narcotics for individual patients, where the medication has significant abuse potential, creates significant societal stresses within VA's community. VA's policy with respect to the management of the population of high narcotic users must be regularly reviewed and supported in order to affect the best possible outcomes for patients.

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VA Program Response
Estimated Resolution Timeframe: FY 2014/2015
Responsible Agency Official: Under Secretary for Health

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Completed Fiscal Year 2014 Milestones

Productivity Standards

Estimated Resolution Timeframe: 2015

Physician productivity standards have been established for 30 specialties representing more than 91 percent of the VHA's physician workforce.

- The standard for each specialty has been set as the FY 2013 mean by Medical Center Complexity Group for each specialty.
- These standards not only cover all physician specialties (including Internal Medicine and Psychiatry), they also include four non-physician specialties (Psychology, Optometry, Podiatry, and Chiropracty).
- These standards have been set for FY 2014 and will be revisited for FY 2015 (with consideration for transitioning to a standard relative to an external benchmark, such as the Medical Group Management Association).
- Only four specialties remain to be implemented: Anesthesiology, Pathology, Emergency Medicine, and Geriatrics.

The Office of Policy and Planning has utilized the Enrollee Health Care Projection Model to project clinical workload (in work Relative Value Units (wRVU)) by facility and by specialty for each of the 30 specialties with productivity standards established for FY 2018.

- These facility- and specialty-specific workload projections are being added to Specialty Productivity- Access Report & Quadrant Tool to provide a future workload trajectory (in wRVU) for guiding resource decisions and integrating operations, budget formulation and execution, and planning.
- Preliminary estimates of staffing requirements for physicians and support staff have been modeled using these Enrollee Health Care Projection Model estimates.

Using the framework and data that VHA put in place to measure physician productivity and staffing, we now use these data to assess capacity.

- The key elements of capacity include: 1) the numbers of clinical providers (physicians and physician extenders), and 2) the specialty-specific productivity expectations (acceptable/achievable levels of productivity) for each of those health care providers. The product of the two represents capacity.
- VHA can increase the number of providers, increase productivity, or increase both to increase capacity.
- Achieving desired levels of productivity for health care providers requires the following: 1) an efficient clinical environment (adequate numbers of exam rooms per provider and efficient clinic space, scheduling support, IT support (automatic appointment reminders for patients to minimize no-shows, etc.), Operating Room availability for surgeons, etc.), and 2) an optimal number and mix of clinic support staff per provider to ensure these providers can practice to the full extent of their license/capability.
- VHA has simulated productivity expectations (moving low performers to the standard) and calculated the appropriate support staff ratios to assist providers to become more productive or maintain productivity, as well as to assist potentially overburdened practices with the necessary physician staffing augmentation.

- These data were used in the assessment of VHA's actions to address national issues about access to care.
- Additionally, VHA used these data to assess for sites at significant risk - inefficient specialty practices (low productivity, poor access) Office of Performance, Efficiency, and Staffing (OPES) staff are actively engaging with these at-risk sites on process improvement.

Audiology Productivity Standard

Estimated Resolution Timeframe: OPES will provide a productivity cube that includes Audiology data by the end of FY 2014.

VHA Audiology Program Office and OPES are collaborating to develop and establish productivity standards for Audiology. OPES will provide a productivity cube that includes Audiology data by the end of FY 2014. OPES is on target to put into development a Rehabilitation Services Productivity Cube that will provide detailed data for Audiologists, as well as other Rehabilitation providers. OPES is responsible for developing the data to assist the program office in establishing policy regarding productivity and staffing.

Electronic Health Record

Estimated Resolution Timeframe: end of FY 2014

VistA Evolution is VA's program to create a seamless medical record for Veterans and modernize the EHR. VistA Evolution's main product is the next generation of VA's EHR system called VistA 4. VistA 4 includes clinical documentation and management features and scheduling functions, among other capabilities. VistA 4 also builds on VistA 3, which is standardization of the core VistA code across facilities.

This effort addresses three of OIG's concerns above: standardizing EHR across facilities with improvements, matching supply of available providers to the demands for healthcare, and management of narcotic users.

VistA standardization: VA standardized much of VistA code through the gold-disk effort of VistA 3. VHA is undertaking the deployment of standardized packages. The first nine standardization sites were completed in Quarter 1 of FY 2014, and standardization will be complete for all 133 VA medical center VistA instances by late 2015. A waiver program allows sites to get approval to maintain site-specific code that has clinical value. VistA 4 will be centrally deployed, similar to the Computerized Patient Record System versions. While the core code will not be subject to local modifications, tools will be provided for controlled customization within certain parameters. VistA 4's centralized software will also allow centralized control of content. This will allow VA to efficiently distribute and maintain, for example, rules for clinical

reminders and decision support. OIT is officially responsible for these efforts with the VHA participation.

Matching demand to available providers: VHA is designing VistA 4 to explicitly address resource management through scheduling, care plans, and activity management. The Medical Appointment Scheduling System is the major acquisition to address scheduling. This new software will provide improved visibility for managers and scheduling clerks into supply and demand for appointments. The system is currently planned for deployment to initial sites by FY 2016 and enterprise-wide deployment complete by FY 2018. OIT is responsible for both projects.

Management of Narcotic Users**:**

In addition to scheduling-software improvements, activity management in the core EHR will help predict and manage clinical based resources. Activity management has two parts: 1) resource management and 2) business-process management. Resource management brings together caregivers, Veterans, Servicemembers and their dependents, material resources, and in the appropriate care settings for diagnostic, therapeutic, or informational tasks. External VA care partners are important members of the care team; therefore, activity management considers and integrates the activities, resource management and communications with these external care team members. Business-process management ensures sequencing of these tasks according to standardized or custom care pathways. Sequencing activities for a given patient across multiple clinical disciplines through a care plan identifies who is doing what, when, and with what resources. Managers will be able to use the outputs of activity management to appropriately allocate resources across time, geography, or virtual modes of interaction. Types of workflows can be evaluated to determine the best productivity and inform future decisions. OIT is primarily responsible with VHA Office of Informatics & Analytics (OIA) participating. Preliminary aspects of activity management will be deployed in FY 2016. Additional functionality will be gradually deployed to full functionality in 2018.

For the management of narcotics, VistA 4 will supplement the aforementioned pharmacy interventions with panel management and population health capabilities. VistA 4 will allow practitioners charged with managing narcotics to customize lists of patients to monitor progress towards goals or increased need and adjust therapy accordingly. OIT is primarily responsible with VHA OIA participating. Patient panel functionality will be deployed with basic functionality in 2016 with increasing functionality through FY 2018.

Operations Oversight

VHA Directive 2009-055, *Staffing Plans*, dated November 2, 2009, established national VHA policy to assist health care facilities in developing formal plans for staffing levels and the proper staff mix in all disciplines to support patient outcomes, clinical

effectiveness, and efficiency. The Directive provides a framework for developing, implementing, and reviewing staffing plans. Managers at the point-of-care (facility level) make staffing decisions about the appropriate mix and level of staff required based on:

- Mandated national staffing levels or methodologies;
- Recommendations from the team providing the care or services; and
- Performance measures, patient outcomes, or other indicators or monitors of the accessibility and quality of care provided.

Recent events have shown marked vulnerabilities in the way care is managed and delivered requiring an approach that balances appropriate measurement, with better self-assessment, and focused plan for improving those areas that are underperforming. VHA needs to ensure appropriate levels of staffing and create hiring strategies for staff in regions of the country that are unusually competitive.   Further, it will be critical that VHA quickly fill leadership positions at facilities and VISNs and subsequently ensures that new leaders are given the advanced skills to maximize success.

As such, VHA is finalizing a new handbook and directive that will define the policy for monitoring and assessing specialty provider group practice productivity and associated staffing levels.   The Assistant Deputy Under Secretary for Health (ADUSH) for Patient Care Services and the ADUSH for Clinical Operations are responsible for the development of the staffing guidelines.   The policy outlines general guidelines VHA facilities must follow on a yearly basis. The guidelines require assessing and measuring productivity and staffing, to include performing needs assessments for hiring.

In addition to increased focus on appropriate staffing, VHA is developing a framework that will combine self-assessment with use of key measures to determine facilities that may have a range of vulnerabilities that could put patient care at risk. These facilities will be paired with top performers to help accelerate and sustain improvements.

Use of Narcotic Medications

Estimated Resolution Timeframe: February 28, 2015

VA has taken steps to enhance prescribing and prescription fulfillment processes to prevent harms associated with the use of pain medications. Included among these steps are the following:

- Deployment of an Opioid Safety Initiative which was implemented nationwide in August 2013.
  - Monitoring of patients dispensed opioids
  - Monitoring of concurrent opioid/benzodiazepine prescribing
  - Monitoring of morphine equivalent daily dose
  - Monitoring of urine drug screens for patients on opioids for longer than 90 days

- To support implementation of the OSI, the National Pain Management Program office, in collaboration with other VHA offices including Pharmacy Benefits Management, Primary Care, and Mental Health (MH), has:
  - Developed detailed clinical guidance recommendations in instructional formats for training clinical teams throughout the VHA in safe opioid prescribing practices and the integration of safe, non-opioid, evidence-based pain therapies;
  - Disseminated this guidance, along with other pain management education developed jointly with the Department of Defense, through educational programs for VHA's Primary Care Services and Patient Aligned Care Teams (PACT), the VHA Pain Management Program's VISN and facility points of contact, and the VHA's pain Website.
- Deployment and implementation of Overdose Education and Naloxone Distribution in April 2014 to prevent harms from intentional or unintentional opioid overdose
- Successful piloting of an Academic Detailing/Psychotropic Drug Safety Initiative which is scheduled for nationwide implementation in Quarter 4, FY 2014
- Distribution of acetaminophen prescribing education information to the field on June 10, 2014. Education information can be found at the following link: http://www.pbm.va.gov/PBM/vacenterformedicationsafety/vacenterformedicationsafetybulletinsandnewsalerts.asp.
- Deployment and implementation of the Medication Order Check Healthcare Application to the field took place on July 9, 2014. The application is expected to reduce inadvertent prescribing harms such as drug interactions
- An Essential Medication Information Directive has been in concurrence since January 8, 2014. This directive will standardize how medication information is displayed to patients and staff.
- VHA Directive 1005, *Informed Consent for Long-Term Opioid Therapy for Pain*, published on May 6, 2014, establishes policy regarding patient education and informed consent for long-term opioid therapy for pain and policy regarding opioid pain care agreements.
- On March 21, 2014, a briefing on the need for a VA Medication Reconciliation/Patient Medication Overarching Strategy was conducted.

OIG Sub-Challenge #1B: Access to Care (VHA)

In response to allegations of gross mismanagement of VA resources and potential criminal misconduct by VA senior leadership at the Phoenix VA Health Care System (PVAHCS) that arose in April 2014, VHA needed to take immediate steps to ensure all Veterans receive appropriate and timely access to care. OIG identified several patterns of obstacles to care that resulted in a negative impact on the quality of care provided by the PVAHCS. Patients recently hospitalized, treated in the emergency department, attempting to establish care, or seeking care while traveling or temporarily living in Phoenix often had difficulty obtaining appointments. Furthermore, although OIG found that PVAHCS had a process to provide access to a mental health assessment, triage, and stabilization, problems were identified with continuity of mental health care and care

transitions, delays in assignment to a dedicated health care provider, and limited access to psychotherapy services.

As of April 22, 2014, OIG identified about 1,400 Veterans waiting to receive a scheduled primary care appointment who were appropriately included on the PVAHCS electronic wait list (EWL). As work progressed, OIG identified over 3,500 additional Veterans, many of whom were on what was determined to be unofficial wait lists, waiting to be scheduled for appointments but not on PVAHCS's official EWL. These Veterans were at risk of never obtaining their requested or necessary appointments.

Subsequent to publication of the interim report on the initial Phoenix HCS allegations, OIG received approximately 225 allegations regarding the PVAHCS and approximately 445 allegations regarding manipulated wait times at other VA Medical facilities through the OIG Hotline, from Members of Congress, VA employees, Veterans and their families, and the media. VA OIG's Office of Investigations opened investigations at 93 sites of care in response to allegations of wait time manipulations. In particular, OIG focused on whether management ordered schedulers to falsify wait times and EWL records or attempted to obstruct OIG or other investigative efforts.

The national implications associated with the concerns of whether the facility's EWL purposely omitted the names of Veterans waiting for care, and at whose direction, and whether the deaths of any Veterans resulted from delays in care have shaken public confidence in VA's system of health care networks. OIG identified a systemic practice to manipulate performance metrics by intentionally leaving patients off wait lists and manipulating wait list data to better reflect performance on facility reports. OIG also identified a prevalent lack of management attention at the level expected of leaders at VHA medical facilities.

OIG's *Audit of VHA's Mobile Medical Units* assessed VHA's use of Mobile Medical Units (MMU) to provide health care access to Veterans in rural areas. This work was requested by the U.S. House of Representatives Committee on Appropriations. OIG found that VHA leadership and program managers knew little about the operations of its MMUs and were not collecting sufficient data to determine whether MMUs improved rural Veterans' health care access. VHA did not know the number, locations, purposes, patient workloads, and general operating costs of the units in this initiative. VHA operated at least 47 MMUs in FY 2013. Medical facilities only captured utilization and cost data in VHA's Decision Support System (DSS) for 6 of the estimated 47 MMUs. Consistent collection of these data could have helped VHA compare MMU utilization and costs with other health care delivery approaches. Such information could have enabled VHA leadership to make assessments and decisions to ensure MMUs provided efficient health care access to Veterans in rural areas. Though sound in concept, this initiative was weakened because VHA leaders did not designate specific program responsibility for MMU management, define a clear purpose for its MMUs, or establish policies and guidance for effective and efficient MMU operations. VHA was unable to demonstrate whether the almost $29 million spent, as well as unknown amounts of

expended medical facility funding, had actually increased rural Veterans' health care access, and if it did, to what extent.

VA Program Response
Estimated Resolution Timeframe: ongoing
Responsible Agency Official: Under Secretary for Health

Completed Fiscal Year 2014 Milestones

Access to Care

VA is in the midst of addressing its most serious crisis in more than a generation. As we begin to tackle nationwide challenges for ensuring Veterans have timely access to health care they have earned, our priorities are clear: 1) to get Veterans off wait lists and into clinics, while also fixing our scheduling system; 2) to address VA's cultural issues, which includes holding people accountable for willful misconduct or management negligence, and creating an environment of openness and transparency; and 3) to use our resources to consistently deliver timely, high-quality health care to our Nation's Veterans.

VHA understood the need for immediate action prior to the release of OIG's Interim Report, *Review of Patient Wait Times, Scheduling Practice, and Alleged Patient Deaths at the Phoenix Health Care System,* on May 28, 2014. From May 12, 2014 through June 3, 2014, VHA conducted a nationwide Access Audit of 731 facilities to determine if allegations about inappropriate scheduling practices were isolated instances of improper practices or if broader, more systemic problems existed. Because initial findings from the audit were a strong basis to commence immediate action, on May 23, VHA:

    a. Deployed the Accelerating Access to Care Initiative. This initiative identified roughly 100,000 Veterans who were currently experiencing long wait times for their VA health care. VHA immediately began contacting these Veterans to accelerate access to care either at VA facilities or through referral to community providers.

    b. Launched the Leading Access and Scheduling Initiative in order to make rapid and definitive changes to ensure integrity in managing Veterans' access to care so we could maintain our focus on providing Veterans timely access to quality health care.

VHA not only responded immediately to the results of the nationwide access audit via Access to Care Initiative and Leading Access and Scheduling Initiative; we also took action to reform access to VA health care including, hiring additional clinical and patient support staff, using temporary staffing measures, deploying Mobile Medical Units, and providing more care by modifying local contracts for community care. In May 2014,

when OIG published its Interim Report, providing VA leadership with four recommendations for immediate implementation, we acted on those recommendations immediately.

    a. OIG recommended that the "VA Secretary take immediate action to review and provide appropriate health care to the 1,700 veterans we identified as not being on any existing wait list." In response:

        i. VA announced on June 4, 2014, that the Department had reached out to all Phoenix, Arizona-based Veterans identified by the IG as not being on any wait list to immediately begin scheduling appointments for all Veterans requesting care.

        ii. Of those Veterans identified by the IG 1,057 Veterans requested and were scheduled for medical appointments.

        iii. As of October 29, 2014, all 1,057 Veterans have been contacted, scheduled an appointment and either completed their appointment or did not show.

    b. OIG recommended that the " VA Secretary review all existing wait lists at the Phoenix Health Care System to identify veterans who may be at greatest risk because of a delay in the delivery of health care (for example, those veterans who would be new patients to a specialty clinic) and provide the appropriate medical care." In response:

        i. As part of the review, VA reached out to more than 5,000 Veterans in Phoenix to coordinate the acceleration of their care. The 1,700 Veterans identified by the OIG are a subset of those 5,000 Veterans.

        ii. Those Veterans included all individuals on the Phoenix VA Health Care System's New Enrollees Appointment Request List , EWL and patients who were waiting greater than 90 days to receive a scheduled appointment.

        iii. Once contact had been made, Phoenix staff scheduled Veterans for appointments based on the Veterans' preference for the timing of their appointments as well as appropriate clinical need.

        iv. Clinical staff attempted to accommodate all needed appointments at the Phoenix VA Health Care System. Where capacity did not exist to provide timely appointments, staff referred patients to non-VA community care in order to provide all Veterans timely access to care.

        v. Since May 15, VA has scheduled 2,300 appointments at the Phoenix VA Health Care System and made 2,713 referrals for appointments to community providers through non-VA care.

    c. OIG recommended that the "VA Secretary initiate a nationwide review of veterans on wait lists to ensure that veterans are seen in an appropriate time, given their clinical condition." In addition, on May 21, 2014, former Secretary Shinseki directed the Veterans Health Administration leadership to personally review their processes to ensure VA is doing everything possible to schedule Veteran patients for timely appointments. In response:

     i.   VA health care facilities nationwide continuously monitor clinic capacity in an effort to maximize VA's ability to provide Veterans timely appointments given their clinical conditions.

    ii.   Where VA cannot increase capacity, VA is increasing the use of care in the community through non-VA medical care.

   iii.   Approximately 200,000 new VA appointments nationwide were scheduled for Veterans between May 15 and June 15, 2014.

   iv.   Additionally, nearly 40,000 individual Veterans have received referrals for their care to private providers in the community in order for Veterans to receive needed care as quickly as possible.

    v.   Each of VA's facilities continuously reaches out to Veterans waiting greater than 90 days for care to coordinate the acceleration of their care.

   vi.   Facility clinical staff continuously evaluate Veterans currently waiting for care to determine if the timing of their appointment is medically appropriate given their individual clinical conditions.

d. OIG recommended that the "VA Secretary direct the Health Eligibility Center to run a nationwide New Enrollee Appointment Request report by facility of all newly enrolled veterans and direct facility leadership to ensure all veterans have received appropriate care or are shown on the facility's electronic waiting list." In response:

    i.   The Health Eligibility Center, in connection with the Veterans Health Administration Support Services Center, developed a report to identify those individuals currently waiting on the NEAR List.

    ii.   As of October 29, 2014, approximately 896 Veterans are on the NEAR list.

   iii.   A preliminary analysis of the 61,900 Veterans removed from the NEAR list shows:

      1. 20 percent cancelled their request for an appointment

      2. 11 percent scheduled an appointment

      3. 2 percent were placed on the EWL

      4. 7 percent requested and were referred to other VA services

      5. 7 percent were in the early stages of eligibility and verification

      6. 52 percent are still in process

      7. Of the 52 percent in process, VA has made several attempts to contact those Veterans by phone. After verifying mailing addresses, VA sent certified letters to every Veteran who could not be reached by phone.

On July 23, 2014, the Interim Under Secretary for Health (USH) chartered a special workgroup to reinvigorate VHA's Performance Management Program, starting with the system-level measures used for the Agency's Performance Plan (APP).   The workgroup will also provide recommendations for restructuring the process of measure governance, with particular attention to how VHA translates its high level priorities into

strategic, tactical, and transactional measures that communicate our priorities and provide feedback for management and operations. VHA's intent is to create an environment in which all VA employees feel engaged with the measures that are used to monitor and improve performance, understand the primacy of Veteran-centered care over "meeting the target," and feel comfortable in raising concerns, regardless of their position in the organization. As this is a large scale overhaul of VHA's entire program planning, budgeting, performance measurement, and evaluation cycle, VHA anticipates the new system to be fully implemented in FY 2016. Preliminary recommendations will be provided to the Interim USH by August 22, 2014.

Additional short term actions are also underway. VHA has removed all waiting-time based performance measures from VHA Senior Executive performance plans, and is seeking approval from the Office of Management and Budget to remove waiting time measures from VHA's FY 2015 Agency Performance Plan (anticipated completion date: September 30, 2014). As of May 30, 2014, facility and VISN Directors were directed to conduct "Listening Sessions" with front-line staff across all scheduling units to engage them in discussing access, integrity, and the integrity of performance measures. Visits to all scheduling units are expected to be completed by December 2014. As of October 29, 2014, 4,000 site visits have been completed.

Mobile Medical Units

VHA issued a memorandum to all VISN Directors to withhold funding for the purchase of new Mobile Medical Units (MMUs) or for new resources for current MMUs until a comprehensive assessment is conducted to assess factors, such as the current composition of the MMU fleet, services provided, operational delays and costs, and the impact on rural Veteran's access to health care. VHA anticipates this review to be completed in September 2014. Contingent upon completion of the comprehensive assessment review, VHA will develop and publish mobile medical unit policies, objectives, strategy for providing program oversight and guidance for effective and efficient operations of MMUs. VHA will assign responsibility for maintaining operational data on MMUs to ensure the resources can be used as part of VHA's emergency plan. Additionally, VHA will implement a mechanism to ensure mobile medical unit-specific operations and financial data are collected in VHA's Decision Support System.

In April 2014, the Office of Finance Managerial Cost Accounting Office (MCAO) sent out guidance to all VA medical centers on how to properly account for MMUs in the DSS. This guidance included instructions on how to acquire a new division number, which is required for proper cost accounting of MMUs. In May 2014, the guidance was redistributed and the facility Directors identified in the OIG report were provided with a status update.

As of September 30, 2014, MCAO reported the following: 1) 42 MMUs require no further action (have acquired division numbers enabling them to be properly accounted for in DSS); 2)23 MMUs pending action in the Veterans Affairs Site Tracking (VAST); 3)

division request need to be initiated; and 4) 0 pending clarification. The reason that the total number of MMUs has grown is that MCAO, in collaboration with the staff at VAST, have uncovered a number of sites that had dual MMUs sharing the same division number. The reason that these sites provided for this practice is that the MMUs provided identical clinical services and often shared staff. These sites have been instructed to acquire a separate division number for each MMU, regardless of the services provided and staff that is shared.

OIG Sub-Challenge #1C: Care of Homeless Veterans (VHA)

The need for timely access to appropriate health care for our homeless Veteran population is also a significant challenge. VA has been involved in street outreach, residential and transitional housing services, vocational rehabilitation, access to primary and MH care, counseling for substance abuse and assistance with benefits for those who qualify. One resource available is VHA's Supportive Services for Veteran Families (SSVF). Under this program, VA awards grants to private nonprofit organizations and consumer cooperatives that can provide a range of supportive services to eligible very low-income Veteran families. Supportive services include outreach, case management, and assistance in obtaining VA benefits and coordinating other public benefits available in the grantee's area or community. The program is designed to rapidly re-house homeless Veteran families and prevent homelessness for those at imminent risk due to a housing crisis. SSVF grantees can make temporary financial assistance payments on behalf of Veterans to third-party providers to cover rent, utilities, security deposits, moving, transportation, child care, and emergency supplies.

The program has been successful in that it provided services to over 62,000 participants in FY 2013 although it was projected to serve only 42,000 for the entire fiscal year. To date, over 80 percent of those discharged from SSVF have been placed in or saved their permanent housing. OIG's review of the SSVF program indicates that the program has adequate financial controls in place and is working as intended to ensure funds are appropriately expended by grantees to care for the homeless.

However, SSVF program leaders can improve controls to ensure only eligible Veterans and their family members participate in the program. OIG found three of five grantees used outdated area median income limits to determine eligibility and were denied benefits. In addition, four of five grantees did not verify Veterans' discharge status with the required Certificate of Release or Discharge from Active Duty (DD 214), which could have allowed non-Veterans to receive benefits for which they were not eligible. For FY 2013, the SSVF Program awarded about $100 million in grants. Grant funding for FY 2014 has increased to $300 million. VHA needs continued diligence to ensure Veterans and families, who are homeless or at risk of homelessness, are adequately served.

VA's Program Response
Estimated Resolution Timeframe: 2014
Responsible Agency Official: Under Secretary for Health

<u>Completed Fiscal Year 2014 Milestones</u>

SSVF will provide email notification to all grantees when area median income (AMI) limits are published by Department of Housing and Urban Development (HUD).   In addition, SSVF will continue to provide guidance on how to find the current AMI in the SSVF Program Guide and through training provided by SSVF Regional Coordinators. On February 21, 2014, the SSVF program office issued HUD's AMI in an email sent to all grantees. The email stated the following:

> "The FY 2014 Area Median Income (AMI) limits were published by HUD at the end of 2013. Grantees should confirm that the AMI limits that they are using are the most current limits. To do this, grantees can go to the HUD User Data Site at http://www.huduser.org/portal/datasets/il/il14/index_il2014.html. They can then click on the gray box for FY 2014 Income Limit Documentation. They can select a state and a county and then click on the next screen button. This will take them to the limits at 30 percent, 50 percent, and 80 percent per household occupants. Grantees are reminded that in order to be eligible for SSVF, a Veteran family must have a gross annual income that is at or below 50percent AMI (which is considered very low-income)."

SSVF issued updated guidance to the field on December 19, 2013, instructing grantees on the SSVF eligibility requirements. Additionally, on December 19, 2013, SSVF conducted a national webinar for all SSVF grantees reviewing eligibility for services. This guidance detailed how grantees can ensure that Veterans are eligible for services. On March 31, 2014, a portion of this guidance was revised to reflect the original application of SSVF program eligibility under the SSVF regulatory definition of Veteran (38 CFR Part 62). VA is reviewing the implications that changes in SSVF eligibility and the application of Veterans under 38 CFR Part 62 might have on homeless and at-risk Veterans and on SSVF grantees. Furthermore, SSVF continues to provide ongoing technical assistance and guidance regarding Veteran eligibility. In addition to written guidance (see Section VI.B. of Program Guide below), SSVF reviewed eligibility during a national conference call in April 2014, in subsequent monthly calls conducted by SSVF staff, and regional meetings held during summer 2014.

The following guidance has been excerpted from the SSVF Program Guide:

> "Veterans eligible for SSVF <u>must also meet </u>the requirements defined for VHA benefits, found at http://www.va.gov/healthbenefits/resources/epublications.asp. To prove a participant's Veteran status, grantees should obtain a copy of the Veteran's Department of Defense (DD) Form 214 Certificate of Release or Discharge from Active Duty (see Section I.D. of Program Guide for definition of

DD Form 214) and keep a copy of that form in the Veteran family's file. VA recommends one or more of the following may be used as verification of Veteran status in lieu of the DD214: a VA Medical Card, HINQ (see below), or proof from VBA of a VA service connected disability.

The Department of Veterans Affairs (VA) utilizes several methods of Veteran eligibility verification:

a. The Health Eligibility Center (HEC) supports VA's health care delivery system by providing centralized eligibility verification and enrollment processing services.
b. Hospital Inquiry System (HINQS) is used by VA Medical Centers to query VBA's compensation and pension BDN to secure information on C&P entitlements and eligibility.
c. Veteran Information Solution (VIS) is a web-based application that provides a consolidated view of comprehensive eligibility and benefits utilization data from across VBA.

To request verification through an existing VIS or HINQS user, grantees can call a designated staff at the local VA medical center with VIS access. Some facilities work out a call process with the VHA registration staff. Grantees unfamiliar with either of these processes may contact their SSVF Regional Coordinator for assistance."

In addition, grantees have been instructed that documents needed to confirm eligibility can also be obtained online through the following resources:

•   E-benefits enrollment: https://www.ebenefits.va.gov/ebenefits-portal/ebenefits.portal
•   Online application for VHA services: https://www.1010ez.med.va.gov/sec/vha/1010ez
•   DD214 online: http://www.archives.gov/veterans/military-service-records/

VA will ensure compliance with AMI guidelines and eligibility requirements through annual monitoring visits conducted by VA Regional Coordinators and contract staff as well as periodic audits conducted by VA's Financial Services Center. Additionally, in order to further ensure compliance, the SSVF Program Office will continue to conduct training on these topics in the first quarter of FY 2015.

<h3 style="text-align:center">OIG CHALLENGE #2: BENEFITS PROCESSING
-Strategic Overview-</h3>

Persistent large inventories of pending claims for compensation benefits pose a continuing challenge for Veterans Benefits Administration (VBA). As of September 2014, this inventory of claims is 515,621, with a backlog of 241,991 claims pending over

125 days. This backlog is attributed to an increase in the disability claims workload, in part due to returning Iraq and Afghanistan Veterans, reopened claims from Veterans with chronic progressive conditions related to Agent Orange, relaxed evidentiary requirements to process post-traumatic stress disorder claims, and additional claims from an aging Veteran population with declining health issues. Complex benefits laws related to traumatic brain injury (TBI) claims as well as court decisions, technology issues, workload management, and staffing concerns also contribute to VBA's benefits processing challenges.

In efforts to address this backlog, VBA has adopted numerous transformation initiatives, including claims digitization and automated processing using the Veterans Benefits Management System (VBMS). VBA has also moved to initiatives such as claims brokering to even out workloads across VA Benefit Offices, provisional ratings for claims over 2 years old, expedited rollout of Disability Benefits Questionnaires, and mandatory overtime for claims raters. Efforts to reduce the backlog of claims waiting to be processed have resulted in VBA actions to reprioritize workloads and reallocate staff from other programs.

OIG reported VBA continues to experience challenges in ensuring its 56 VA Benefit Offices comply with VA regulations and policies and deliver consistent operational performance. Some initiatives to reduce the claims backlog were put in place without adequate controls. OIG continues to report the need for enhanced policies and procedures, training, oversight, quality reviews, and other management controls to improve the timeliness and accuracy of VBA's disability claims processing. OIG reports issued in 2014 highlight continued VBA challenges in managing the claims backlog and ensuring accuracy in disability benefits processing.

Delivering timely and accurate benefits is central to VA's mission. VBA is responsible for oversight of the nationwide network of VA Benefit Offices that administer a range of Veterans benefits programs, including compensation, pension, education, home loan guaranty, vocational rehabilitation and employment, and life insurance. These programs are estimated to pay out over $73 billion in claims to Veterans and their beneficiaries in FY 2015, and comprise approximately half of VA's total budget.

OIG conducts inspections of VA Benefit Offices on a 3-year cycle to examine the accuracy of claims processing and the management of Veterans Service Center (VSC) operational activities. After completion of the inspections, reports are issued to each VA Benefit Office Director on the inspection results. These inspections address the processing of high-risk claims such as TBI and temporary 100 percent disability ratings. In FY 2013, OIG initiated the second cycle of reviews of all VA Benefit Offices. Furthermore, OIG is also performing separate reviews focused on two of VBA's major initiatives related to accuracy of electronic processing of claims using VBMS and effectiveness of provisional decisions under the Special Initiative to Process Rating Claims Pending Over 2 Years. For example, at the end of June 2013, VBA reported 516,922 rating claims pending in its backlog, including 1,258 rating claims pending over

2 years. For that same time frame, OIG estimated that 7,823 provisionally-rated claims had been removed from the inventory although they were still waiting for final decisions. These 7,823 provisionally-rated claims represent less than 2 percent of VBA's reported backlog; however, they represent over 12 percent of the claims completed under the special initiative.

OIG Sub-Challenge #2A: Improving the Accuracy of Claims Decisions (VBA)

VA Benefit Office staff faced challenges providing accurate decisions on Veterans' disability claims. For our inspections, OIG sampled claims with certain medical disabilities considered to be at higher risk of processing errors, thus results do not necessarily represent a VA Benefit Office's overall accuracy in processing disability claims. Claims processing that lacks compliance with VBA procedures could increase the risk of improper payments to Veterans and their families.

From October 2013 through June 2014, OIG inspected 16 VA Benefit Offices and reported on their performance in 5 claims areas:

- Temporary 100 percent disability evaluations for service-connected conditions requiring surgical or medical treatment.
- TBI.
- Special Monthly Compensation (SMC).
- Systematic Analyses of Operations (SAO).
- Benefits Reductions.

OIG determined VA Benefit Office staff did not correctly process 35 percent of the total 977 claims sampled primarily due to a lack of oversight and training. Specifically, VA Benefit Office staff incorrectly processed:

- 52 percent of 359 temporary 100 percent disability evaluations, resulting in nearly $3 million in improper payments within this sample of national claims.
- 18 percent of 326 TBI claims reviewed. OIG found that TBI claims processing errors resulted from staff using VHA medical examination reports that did not contain sufficient information to make accurate rating determinations. Staff generally over-evaluated the severity of TBI-related disabilities because they did not properly interpret the medical examination reports.
- 37 percent of 292 claims involving SMC and ancillary benefits.

VBA's management of temporary 100 percent disability evaluations is considered ineffective and as a result OIG sees significant risks of improper payments. In OIG's June 2014 report, *Follow-up Audit of VBA's 100 Percent Disability Evaluations,* the objective was to determine whether VBA took sufficient action to implement Recommendation Seven from the prior 2011 OIG report. The recommendation was to "Conduct a review of all temporary 100 percent disability evaluations and ensure each

evaluation has a future exam date entered in the Veterans' electronic records." OIG previously reported in the 2011 *Audit of 100 Percent Disability Evaluations* that VBA was not correctly evaluating and monitoring 100 percent disability evaluations. At that time, OIG projected that VA Benefit Office staff did not correctly process 100 percent disability evaluations for about 27,500 (15 percent) of 181,000 Veterans. The 27,500 disability evaluations included over 9,900 Veterans with temporary 100 percent disability evaluations without future exam dates entered in the electronic record. Without improved management of these claims, VBA could overpay Veterans a projected $1.1 billion in the next 5 years.

As of January 2014, VBA identified over 8,300 temporary 100 percent disability evaluations for VA Benefit Offices to review; however, 7,400 (88 percent) had not been reviewed. Further, OIG estimated 3,100 (42 percent) of these Veterans had received almost $85 million in improper benefit payments since January 2012 because their claims lacked adequate medical evidence. OIG remains concerned about VBA's financial stewardship of these claims and projects that without action, VBA could continue making unsupported payments to Veterans totaling about $371 million over the next 5 years. The most recent OIG follow-up audit reported a $456 million ($85 million plus $371 million) total impact to the Government. This projection was reduced to $222.6 million for reporting purposes because the 2011 projection and report included all benefits before December 31, 2015.

The pressure to reduce the backlog has had a negative and sometimes unintended impact on other aspects of claims processing. On April 19, 2013, VBA began a special initiative to process all claims pending for 2 years or more. VA Benefit Office staff were to issue decisions on all these within 60 days if there was sufficient evidence to make a decision. As such, a new "provisional" rating category was established. VBA applied this initiative to all claims received on or before July 1, 2011. VBA identified a total of 62,600 claims under this initiative. However, VBA's provisional rating policy was not fully effective in meeting the special initiative goals. In comparison with the existing intermediate ratings policy, provisional ratings provided some claims decisions faster, but did not allow benefits to be granted more quickly. Further, by removing provisionally-rated claims from the backlog, VBA misrepresented its workload statistics and progress toward backlog elimination.

OIG takes exception to VBA's procedures in its provisional ratings policy because it focused on providing decisions that removed these claims from the pending inventory. VBA considered claims to be complete upon issuance of provisional ratings in spite of Veterans still awaiting final ratings decisions. Further, VA Benefit Offices did not prioritize finalization of provisionally-rated claims once they were no longer considered part of the backlog. OIG estimated 6,000 Veterans with provisional ratings were awaiting final decisions as of January 2014. VBA did not always ensure electronic system controls were functioning as intended to remind of the need for future actions to finalize these provisional ratings. VBA also did not accurately identify all provisionally-rated claims that needed to be tracked and managed through to finalization. Because
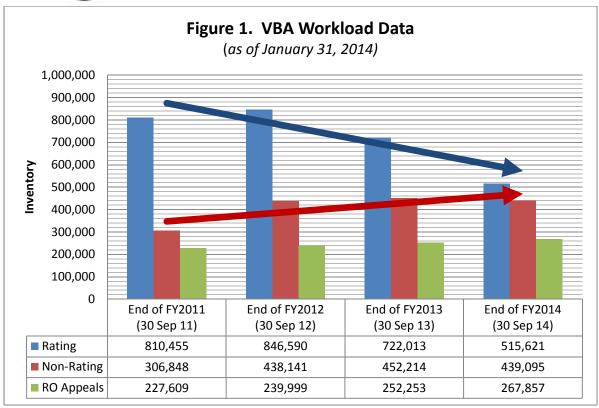
of this lack of controls, some Veterans may never have received final rating decisions if not for OIG's review.

VBA also did not accurately process 77 (32 percent) of 240 rating decisions issued under the special initiative. Generally, these errors occurred because VA Benefit Offices felt pressured to complete these claims within VBA's 60-day deadline. OIG estimated VA Benefit Office staff inaccurately processed 17,600 of 56,500 claims, resulting in $40.4 million in improper payments during the special initiative period.

There is a correlation between the special initiative and recent VBA statistics that the claims backlog is decreasing. The backlog has actually decreased by 17 percent since the end of FY 2011. However, claims not counted in the inventory (non-inventory rating) are increasing—by a staggering rate of almost 51 percent during the same period. VBA's special initiative to reduce the number of claims pending over 2 years or more provides an example of how, if not why, this is happening. In essence, when claims were reviewed under this initiative, claims that were ready-to-rate (having sufficient evidence on file) were completed and granted, or denied. Claims awaiting certain evidence were given a provisional rating, for which the criteria are quite complicated. These claims were electronically coded to "be reviewed and rated in 365 days" and taken off the inventory. VBA sent notification to the Veterans, advising of the 'provisional' ratings and requesting the evidence needed to support their claims. However, these claims were no longer treated as pending claims. Thus, the inventory of pending claims dropped while claims in the non-inventory category increased.

Figure 1 illustrates the shift in the claims processing workload for about the last 3 years.

Figure 1. VBA Workload Data
(*as of January 31, 2014*)

	End of FY2011 (30 Sep 11)	End of FY2012 (30 Sep 12)	End of FY2013 (30 Sep 13)	End of FY2014 (30 Sep 14)
■ Rating	810,455	846,590	722,013	515,621
■ Non-Rating	306,848	438,141	452,214	439,095
■ RO Appeals	227,609	239,999	252,253	267,857

A key point of interest is the increased appeals inventory resulting from VBA's focus on eliminating the claims processing backlog. OIG is committed to performing more work in this area until a clear and decisive accounting of the claims workload is available and the processes are transparent to VA decision–makers.

Further, OIG is concerned that the pressure to complete claims under the special initiative has led to a high number of errors. Claims are typically reviewed by VBA's internal quality control staff at the VA Benefit Office, as well as a sample of claims reviewed by the Systematic Technical Accuracy Review (STAR) team. However, work under the special initiative was expected to be completed within 60-days at the direction of the Under Secretary. As such, VA Benefit Office management advised that the quality of the decisions made in processing these claims was not assessed. VA Benefit Office staff also advised OIG that neither internal quality reviews nor STAR reviews were undertaken for claims processed as part of this special initiative until after the initiative was completed. The pressure to meet the 60-day deadline led to incorrect processing of as many as one-third of the claims processed under the special initiative. Errors included insufficient evidence to make a decision, incorrect evaluation of a Veteran's disabilities, incorrect effective dates for payment, not deciding on all issues in the claim, and not properly notifying the Veteran of a decision. Despite the fact that the special initiative resulted in over 62,000 claims processed in 2 months, the net gain might not be what was expected.

Another aspect of VBA's challenge to ensure accurate claims payments is ensuring Veterans are not concurrently compensated when performing their Reservist or National Guard obligations. Federal regulations prohibit Reservists and National Guard members from concurrently receiving VA compensation or pension benefits along with military reserve pay, also known as "drill pay." OIG determined VBA did not timely process VA benefits offsets when drill pay was earned concurrently. According to VBA, higher priorities, such as processing compensation claims, took precedence over processing offsets. VBA also lacked an adequate tracking mechanism, a current cost-benefit analysis, and SAO reviews of the drill pay offset process. VBA's rate of unprocessed offsets reported in OIG's 1997 audit was almost the same as the rate in the current review. Therefore, VBA has not processed hundreds of millions of dollars in offsets since OIG's previous report. VBA could recover millions in improper payments using the offset process. OIG's 2014 audit estimated that VBA could recover approximately $623.1 million in improper payments.

VA Program Response
Estimated Resolution Timeframe: 2015
Responsible Agency Official: Under Secretary for Benefits

Completed 2014 Milestones

As part of its largest transformation in history to fundamentally redesign and streamline the way it delivers benefits and services, VBA is now electronically processing over 90 percent of its claims inventory in a new digital environment, the Veterans Benefits Management System (VBMS). Combined with such initiatives as increased brokering of claims, centralized mail, access to the Social Security Administration's Government Services Online system, electronic service treatment records, and mandatory overtime, VBA completed a record-breaking 1.3 million disability rating claims in FY 2014, compared to the previous record of 1.17 million claims in FY 2013. In conjunction with recent training, such as the Specialized Adjudication Review and Supervisory Technical Analysis of Data courses, claim-level accuracy increased from 83 percent in June 2011 to 90.4 percent as of September 30, 2014; accuracy is 96 percent at the issue-level.

Although VBA focused on its priority goal to eliminate the disability rating claims backlog for Veterans who have been waiting the longest, and is achieving record-breaking levels of production, VBA did not ignore non-rating claims. VBA continued to complete more non-rating work each year; however, as more rating claims are processed, non-rating receipts increase. VBA completed 2.7 million end products beyond the record breaking rating-related work accomplished in FY 2014, an increase of approximately 170,000 over FY 2013. VBA is now handling non-rating workload such as dependency claims by using contractors, National Call Centers, and the Rules-Based Processing System, which automatically processes such claims.

As of September 30, 2014, VBA's pending workload included: 515,621 claims awaiting a rating decision, 439,095 non-rating claims, and 267,857 appeals at regional offices.

VBA's "Oldest Claims" initiative was launched in April 2013 and ended on November 8, 2013. During this timeframe, VBA rendered over 500,000 rating decisions to Veterans who had been waiting the longest for a decision on their claim. Of those, about 14,800 (less than 3 percent) of the decisions rendered during this timeframe were "provisional" rating decisions. Of these decisions, 10,277 (71 percent) granted service connection for at least one condition.

On June 2, 2014, VBA directed a complete review of all provisional rating decisions to be concluded by September 1, 2014, or at least one year after the provisional rating was issued (whichever was later), unless additional evidence needed to correctly decide the claim remained outstanding. With the exception of five cases pending at the Board of Veterans' Appeals, regional office Quality Review Teams reviewed all provisional decisions to determine if the ratings were completed properly, if a final rating was warranted, or if further development was necessary.

VBA updated the Traumatic Brain Injury Training and Performance Support System (TPSS) module, which is required for all rating personnel assigned to Special Operations, Appeals, or Quality Review Teams. In July 2014, VBA reminded RO personnel when to rate co-morbid mental disorders separately from other TBI residuals.

In December 2013, VA corrected a defect in the Special Monthly Compensation Calculator that impacted the basic rate in cases at the SMC R1 and higher level.

VBA redistributed resources to focus on processing drill pay waivers and offsets. In May 2014, VBA modified the existing internal controls Systematic Analysis of Operations (SAO) requirement for regional offices to also include an analysis of drill pay matching activities to better monitor these reviews, identify existing or potential problems, and evaluate the effectiveness of any corrective actions taken. All regional offices will complete this on their standard, annual SAO completion schedule.

VBA implemented an aggressive plan to ensure appropriate action is taken on all temporary 100 percent disability evaluations either within 180 days of their inclusion on the temporary 100 percent report, or upon the maturation of the future examination indicator that is established when VA awards a Veteran a temporary 100 percent evaluation.

OIG Sub-Challenge #2B: Improving the Management of VBA's Fiduciaries (VBA)
OIG substantiated allegations of mismanagement at VBA's Eastern Area Fiduciary Hub, including systemic misuse of beneficiary funds. The Fiduciary Program oversees the benefits paid to Veterans, or family members, who are incapable of handling their financial affairs either because of injury, disease, infirmities of advanced age, or being under 18 years of age. Under the program, VA appoints a fiduciary (individual or entity) to receive and disburse VA benefits on behalf of the beneficiary. As of August 2013, the

Fiduciary Program reported providing oversight of fiduciaries responsible for more than 150,000 beneficiaries. Field examinations are 'spot-checks' by VBA officials to ensure beneficiaries are being cared for as expected and that fiduciaries are doing their jobs as required.

OIG noted VBA leaders failed to take the required actions when misuse of beneficiary funds was identified. OIG determined VBA staff was negligent in its oversight of the fiduciaries' misuse of funds. Further, actions (when taken) were not within standards—in some cases VBA took no action when misuse occurred. As a result, VA could be responsible for repayment of approximately $944,000 to the affected beneficiaries.

In addition, OIG substantiated VBA had a large backlog of pending field examinations, specifically at this Fiduciary Hub. More than 11,000 (69 percent) of 16,000 pending field examinations had not been completed within the 45 days established in its timeliness standards. As a result, the general health and well-being of beneficiaries are placed at increased and unnecessary risk. OIG also identified more than 3,200 pieces of mail that had yet to be processed and exceeded processing timeliness standards at this Fiduciary Hub. Some of these documents were time-sensitive and critical to the Veterans' receipt of the proper health care and benefits. Delays in processing the 3,200 pieces of mail ranged from 11 to 486 workdays, with an average delay of 30 workdays. Without effective management of incoming mail, those receiving VA benefits could be negatively affected.

VBA beneficiary funding managed by the Fiduciary Program are at risk for fraud based on program weaknesses. From April 1, 2009, to March 31, 2014, OIG conducted 146 investigations involving fiduciary fraud and arrested 79 fiduciaries and/or associates. OIG investigations highlight program vulnerabilities that are exploited by unscrupulous individuals at the expense of VA beneficiaries.

Three recent examples illustrate the effective approach OIG has in combating fiduciary fraud by pursuing prosecution and court-ordered restitution against those individuals diverting funds intended for VA beneficiaries. In the first example, an OIG investigation revealed that a VA-appointed fiduciary diverted for his own use $8,208 of his father's VA benefits. In April 2013, after pleading guilty to charges relating to his theft, the subject was sentenced to 20 months' incarceration and ordered to pay $8,208 in restitution. In the second example, an OIG investigation revealed that a VA-appointed fiduciary, while employed with a professional financial services company, diverted $17,000 in funds intended for the Veteran. The fiduciary was arrested and in February 2014 agreed to a pretrial diversion agreement requiring repayment of $17,000 in restitution to the Veteran. In the last example, an OIG investigation revealed that a VA-appointed fiduciary diverted $26,108 of a Veteran's funds for his own personal use. The subject was indicted, arrested, and in December 2013, agreed to a pretrial diversion agreement requiring him to pay $26,108 in restitution to the Veteran.

VA Program Response
Estimated Resolution Timeframe: 2015
Responsible Agency Official: Under Secretary for Benefits

Completed 2014 Milestones

VBA has made significant changes to the fiduciary program to improve the services it provides to beneficiaries who cannot manage their VA benefits. VBA improved the processing of fiduciary matters when it deployed a new fiduciary workload management system, the Beneficiary Fiduciary Field System (BFFS), in May 2014. BFFS provides the ability to track, manage, and report on the status of misuse of benefits by fiduciaries throughout the entire process, from allegation through debt collection. VBA centrally monitors the information in BFFS to ensure oversight of fiduciaries and confirm field compliance with program policies and procedures.

In FY 2014, VBA took steps to improve the identification and prevention of misuse of beneficiary funds. VBA developed new misuse training designed for the specific responsibilities of field employees. This mandatory training course will be deployed during the first quarter of FY 2015. BFFS automates the misuse protocol and ensures that field personnel address all steps in the standardized process. In addition, in November 2013, VBA implemented new procedures (VBA Fiduciary Misuse Debt Processes) to ensure that field employees initiate debt collection from fiduciaries who misuse the benefits they were entrusted to protect. VBA also made it easier to track fiduciary debts in both the Centralized Administrative Accounting Transaction System (CAATS) and the Financial Management System. The new BFFS system includes data fields to monitor and report on debt establishment, payments received, and reissued benefits. BFFS provides this data regarding fiduciary activities occurring after deployment of the system, and fiduciary program personnel will use it to compile and maintain misuse case reports.

In February 2014, VBA deployed an "Accounting Wizard," which it later incorporated in BFFS, for Legal Instrument Examiners to use when auditing accountings. The tool improves accounting auditing accuracy, reduces common processing errors, and improves efficiency by automatically generating correspondence and accounting packages.

VBA has implemented a plan for field examiners at the Eastern Area Fiduciary Hub (EAFH) to process both initial appointment and fiduciary-beneficiary field examinations timely. In March 2014, the EAFH implemented a plan to eliminate its backlog of field examinations by the end of FY 2015. The EAFH also created new standard operating procedures to process all incoming hub mail based on the date of its initial receipt at VA.

In its first major update to the fiduciary regulations since the 1970s, VA prescribed new rules for all aspects of the program's administration, specifically the rights of

beneficiaries and the roles of VA and fiduciaries. On January 3, 2014, VA published the proposed regulations in the Federal Register (79 Fed.Reg.429). Final regulations are under development, and VA anticipates completion by the end of December 2014.

In FY 2014, VBA established promulgation teams in the Fiduciary Hubs. These teams issue final decisions regarding beneficiaries' ability to manage their VA benefits, initiate monthly benefit payments to fiduciaries on behalf of beneficiaries, and release beneficiaries' retroactive payments to their fiduciaries. This new process ensures timely release of benefits to beneficiaries and eliminates hand-offs between VBA's Pension Management Centers, Veterans Service Centers, and Fiduciary Hubs.

OIG Sub-Challenge #2C: Improving Access to Benefits for Rural Veterans (NCA)

Congress expressed concerns that the National Cemetery Administration (NCA) is not adequately serving the Nation's Veterans residing in rural areas. Some concerns included identifying the number and geographical areas where rural Veterans are unserved, assessing gaps in service between rural and urban Veterans, recommending appropriate policy on new national cemeteries to serve rural areas, and developing a national map showing locations and number of unserved Veterans. NCA's Rural Veterans Burial Initiative does not adequately identify the number and percentage of Veterans residing in rural areas who do not have reasonable access to a burial option.

OIG determined that prior to the planned NCA Rural Veterans Burial Initiative, NCA was not providing reasonable access to a burial option for approximately 302,000 (34 percent) of about 888,000 rural Veterans in the initiative's 8 targeted states. When completed, NCA's Rural Veterans Benefits Initiative was expected to decrease the total number of unserved rural Veterans by nearly 120,000 (40 percent) to about 182,000 in these 8 states.

OIG's review indicated NCA could not adequately identify the number and percentage of unserved Veterans who reside in rural areas because it uses a methodology that identifies Veterans residing within a 75-mile radius of a national, VA-funded state or tribal organization Veterans' cemetery, and does not classify Veterans as rural, urban, or any other designation. In addition, NCA leadership lacked a specific performance measurement that evaluated NCA's progress towards increasing service to rural Veterans. As a result, NCA cannot evaluate the level of service provided to Veterans and their families residing in rural areas throughout the eight targeted states and the entire Nation. Without this specific Veteran population information, NCA cannot adequately report to Congress and other stakeholders its performance serving rural Veterans.

VA Program Response
Estimated Resolution Timeframe: 2015
Responsible Agency Official: Acting Under Secretary for Memorial Affairs

Completed 2014 MMC Milestones

With the establishment of 13 new national cemetery facilities currently planned, NCA will serve 96percent of the Veteran population with access to a burial option. While NCA cannot quantify the percent of the Veteran population that may be identified as rural, it is clear that a substantial number of rural Veterans have been and will be provided access to a burial option using our current methodology of locating cemeteries in areas of greatest need based on county level Veteran population. In order to provide more specific Veteran population information, NCA concurred with all three recommendations in the OIG report and began work in late FY 2014 to address these recommendations. NCA is developing new analytical tools, including a new database, which will enable NCA to "drill down" and better identify and analyze the level of service VA provides to veterans in rural areas. These tools will also enable NCA to develop performance measures specific to the level of service provided to rural veterans and to develop a national map that shows the distribution of rural veterans who are considered to be served by a burial option within a reasonable distance of their residence. VA expects to complete the work to address these recommendations by the middle of FY 2015.

Planned FY 2015 Milestones with Estimated Completion Quarter

1) Develop a methodology to identify the number and percentage of served and unserved rural veterans throughout the Nation – First Quarter FY 2015
2) Produce a national map showing the areas and number of served and unserved rural veterans – First Quarter FY 2015
3) Establish performance goals for the percentage of rural and urban veterans served – Second Quarter FY 2015

OIG Sub-Challenge #2D: Management and Administration of Education Benefits (VBA)

Since its inception, the Post 9/11 G.I. Bill education assistance program has been difficult for VA to manage successfully. OIG evaluated VBA's administration of Post 9/11 G.I. Bill monthly housing allowance and book stipend payments. There are significant risks in the program due to its size and the amount of the budget for education benefits delivery. During calendar year 2013, VBA paid about $5.4 billion in housing allowances and book stipends to approximately 789,000 students. OIG found students generally experienced payment processing delays in their housing allowance and book stipends. In addition, VBA improperly paid book stipends that were not collected from students after they withdrew from courses. Thus, OIG estimated students annually experience about $60.8 million in payment processing delays and about $41 million in improper or inaccurate payments.

Inaccurate filings from the students caused significant delays; however, VBA did not effectively monitor schools to ensure they timely submitted accurate enrollment information. VBA staff processing errors and computation problems in the automated claims processing system also caused inaccurate payments.

VA Program Response
Estimated Resolution Timeframe: 2015
Responsible Agency Official: Under Secretary for Benefits

Completed 2014 Milestones

Since deploying the Long Term Solution end-to-end automation feature for processing education claims in September 2012, VBA significantly improved the timeliness of Post-9/11 GI Bill payments. Prior to this deployment, VBA faced timeliness challenges during the 12-month period ending March 31, 2013, covered by the OIG report. During FY 2014, Veterans received their Post-9/11 GI Bill payments and eligibility determinations quickly as original claims were processed in an average of of 16.7 days and supplemental claims in an average of 5.9 days. VBA reviewed 43 cases that OIG identified with improper payments, as defined by the Improper Payments Elimination and Recovery Act, and took action to appropriately recover these debts.

VBA addressed the timeliness of enrollment submissions by schools by determining and establishing a timeliness standard for submitting initial enrollment certifications. The approved standard was published in the School Certifying Official (SCO) Handbook and is reviewed during compliance visits with the SCOIn addition, on August 20, 2014, VBA's quarterly webinar reiterated the availability and importance of the online School Certifying Official training and the importance of schools submitting timely and accurate enrollment certifications.

VBA reviewed the current methodology for quality reviews to determine the feasibility to track and report by document type. A new methodology has been identified to track enrollment documents by type within the sample population. VBA will implement the new methodology beginning FY 2015.

In addition, VBA issued a training reminder to the education liaison staff to regularly update school information in the Web Enabled Approval Management System and include accurate full-time equivalency information in the schools' profiles. During the week of August 4, 2014, VBA also addressed this topic during a training conference.

OIG CHALLENGE #3: FINANCIAL MANAGEMENT
-Strategic Overview-

Sound financial management represents not only the best use of limited public resources, but also the ability to collect, analyze, and report reliable data on which resource use and allocation decisions depend. VA's failure in some instances to ensure accurate payments to Veterans through its range of compensation, education, and medical service programs is one way in which improper payments occur. VA could also improve accuracy in initiating and monitoring Workers' Compensation Program (WCP) claims to return employees to work when they are medically able. Addressing these and other issues related to financial systems, information, and asset management would promote improved stewardship of the public resources entrusted for Departmental use.

For the 15th consecutive year, OIG's independent auditors provided an unqualified opinion on VA's FYs 2013 and 2012 consolidated financial statements (CFS). VA has demonstrated improvement in one aspect of its financial stewardship. VA took sufficient corrective action to eliminate the one significant deficiency concerning undelivered orders that was cited the previous year. However, the auditors identified one material weakness: information technology security controls, a repeated condition. The auditors also provided to VA management officials several observations and recommendations concerning internal control weaknesses that did not rise to the level of significant deficiency or material weakness for purposes of the Independent Auditors' Report issued on November 26, 2013. OIG considers the observations and recommendations to be informative, significant, and worthy of management's attention and corrective action. The independent auditors will follow up on these internal control and compliance findings and evaluate the adequacy of corrective actions taken during the FY 2014 audit of VA's consolidated financial statements.

OIG Sub-Challenge #3A: Compliance with the Improper Payments Elimination and Recovery Improvement Act (OM)

OIG conducted the FY 2013 review of VA's compliance with the Improper Payments Elimination and Recovery Act (IPERA). VA reported $1.1 billion in improper payments in its FY 2013 Performance and Accountability Report (PAR). OIG's assessment of VA's compliance with IPERA for FY 2013 is based on FY 2012 data as reported by VA. OIG found VA met five IPERA requirements for FY 2013 by publishing a PAR, performing risk assessments, publishing improper payment estimates, providing information on corrective action plans, and reporting on its payment recapture efforts. VA also implemented a new risk assessment process in FY 2013 across all of its programs.

VA did not comply with two of seven IPERA requirements for FY 2013. VHA reported a gross improper payment rate of greater than 10 percent for one program and did not meet reduction targets for two programs. This represents an improvement over FY 2012 when VA did not comply with four of the seven IPERA requirements. Nonetheless, OIG identified areas for improvement in VBA's IPERA reporting. VBA underreported improper payments for its Compensation program. Test procedures for the Compensation program and one Education program also did not include steps needed to identify all types of improper payments. OIG recommended the Under Secretary for Health (USH) implement the corrective action plan included in the PAR to reduce improper payments for the State Home Per Diem program, and develop achievable reduction targets for that and Beneficiary Travel programs. OIG also recommended the Under Secretary for Benefits (USB) ensure thorough procedures for testing sample items used to estimate improper payments for the Compensation and Post 9/11 G.I. Bill programs.

VA Program Response
Estimated Resolution Timeframe: December 2016
Responsible Agency Official: Under Secretary for Benefits and Under Secretary for Health

VHA's Chief Business Office (CBO) has started to implement the corrective action plan included in the 2013 Performance Accountability Report to reduce improper payments for the State Home Per Diem (SHPD) program. A new database was established to capture and retain Veteran admission and payment documentation. Veterans Affairs Medical Center staff were consulted to mitigate application (10-10SH) and other documentation errors to ensure compliance with SHPD program requirements. Audit staff was increased by five personnel to measure improper payments. A system-wide electronic tracking tool has been implemented, which calculates the daily cost of care and validates payment accuracy.

Deployment of an automated 10-10SH application to ensure completion of required fields and enhance transmission is still in progress. Revision of the SHPD program handbook to facilitate standardization of program requirements is also in progress.

VBA re-evaluated and expanded the number of Compensation payment attributes tested for FY 2014 improper payment reporting (FY 2013 data testing), which resulted in a more thorough test plan. VBA improved QA measures, which included multiple levels of supervisory review and validation of identified improper and random proper payments prior to submission.

VBA's Education Service reviewed the current methodology for quality reviews to determine the feasibility to track and report by document type. A new methodology has been identified to track enrollment documents by type within the sample population. Education Service will implement the new methodology beginning in FY 2015. Additionally, VBA issued a training reminder to the education liaison staff to regularly

update school information in the Web Enabled Approval Management System, which includes accurate full-time equivalency information in the schools' profiles During the week of August 4, 2014, VBA also addressed this topic during a training conference.

OIG Sub-Challenge #3B: Ensuring Accurate Initiation and Effective Monitoring of Workers' Compensation Program Claims (VHA)

VHA has not improved its Workers' Compensation Program (WCP) claims management since OIG's prior audits. OIG identified issues with claims initiation and monitoring similar to those disclosed in the 2004 and 2011 audit reports. Specifically, WCP case files lacked initial or sufficient medical evidence to support connections between claimed injuries and medical diagnoses. As such, OIG estimated VHA inaccurately initiated about 56 (7 percent) of 793 WCP claims. In spite of the 2011 recommendations, VHA still lacked standard guidance and a clear chain of command to ensure compliance with WCP statutory requirements and VA policy. As a result, VHA risks paying unnecessary costs for inaccurately initiated claims.

WCP claims also were not consistently monitored to timely return employees to work. VHA WCP specialists did not consistently monitor files, make job offers, or take actions to detect fraud. This occurred because of inadequate oversight, misinterpretation of requirements, and a lack of staff. VHA also lacked a fraud detection process. As a result, VHA risks continuing improper payments to ineligible claimants. OIG projected 489 (61.7 percent) of 793 active claims were inadequately monitored. Overall, OIG estimated VHA could reduce WCP costs over the next 5 chargeback years by about $11.9 million through improved claims initiation and $83.3 million by increasing efforts to return medically-able staff to work. In total, opportunities exist for VHA to reduce WCP costs by about $95.2 million with improved claims management. OIG also identified $2.3 million in unrecoverable payments.

OIG recommended the USH ensure clear oversight, standard guidance, adequate staff, and fraud detection procedures to improve VHA's WCP case management.

VA Program Response
Estimated Resolution Timeframe: May 2015
Responsible Agency Official: Under Secretary for Health

Completed Fiscal Year 2014 Milestones

Initial documentation of case files is being fully addressed by actions described here. In July 2013, VHA National Workers' Compensation Program (the program office) and the Center for Engineering and Occupational Safety and Health developed and published the VHA Workers' Compensation (WC) Guidebook, which includes processes and procedures to help VHA VISN and facility WCP staff effectively implement, staff, and manage a local WCP. The VHA WC Guidebook contains sections on *Basic Requirements of a Claim, WCP Staff Responsibility*, and *Questionable Claims*, which

outline the required steps to evaluate the validity of a claim. In April 2014, the Program Office trained facility WCP staff on Case File Management and File Maintenance focused on case file documentation standards. In July 2014, the program office developed a Program Bulletin to provide instruction and a case file review checklist to assist the facility WCP staff understand documentation standards and provide a tool to ensure required documents are present in a case file. The program office scheduled a WC Case Review Lync Meeting for August 27, 2014, to discuss with local WCP staffs, the appropriate processes to evaluate the validity of claims and challenge the five requirements of a claim appropriately.

VHA developed processes and monitors to consistently track timely return to work. The VHA WC Guidebook also contains sections on *Return to Work* and *Permanent Job Offers*, which outline the required steps to appropriately return injured employees to work. In October 2013, the program office established a standard operating procedure (SOP) and implemented a Memorandum of Understanding (MOU) to initiate a Quality Case Management (QCM) process to evaluate local WCP activities including claims initiation, initial case management, appropriateness of claims, controversies and disputes; and return-to-work processes. Deficiencies are addressed with the local WCP staff responsible for the work. Training is provided during case review meetings and through communications such as Program and Technical Bulletins communicated to all WCP staff. In July 2014, the program office conducted two WC Case Review Lync Meetings with local WCP staff on effective return-to-work processes.

Responsibility for policy, planning, training, and oversight and compliance of the VHA National WCP is delegated to the program office. In FY 2013, the program office developed a standardized protocol to perform oversight through site visits of local WCPs and through the QCM MOU. In FY 2014, the program office conducted 14 site visits, trained VISN WCP Coordinators in the site visit process and funded two additional site visits in each VISN. Ten additional site visits have been conducted by VISN WCP Coordinators. In FY 2014, the program office conducted a staffing analysis and identified VHA facilities that are not meeting the 1:1200 Fully-time Employee Equivalent (FTEE) ratio outlined in the Human Resources Delivery Model (HRDM) 2010 approved by the Under Secretary for Health. The program office discusses staffing during each WCP site visit and periodically monitors local WCP staffing vs. employee FTEE.

The VHA WC Guidebook also refers local WCP staff to the "Office of Inspector General's (OIG) Protocol Package For Veterans Integrated Service Network Workers' Compensation Program Case Management and Fraud Detection" (OIG Report: 9D2-G01-002, Publication Date: April 14, 1999) as the standard for evaluating cases for potential fraud and referring cases to OIG. This report can be accessed at the following link: http://www.va.gov/oig/52/reports/1999/9D2-G01-002.pdf. In FY 2014, the program office developed a streamlined checklist for local WCP staff to evaluate characteristics of potential fraud.

The program office scheduled a WC Case Review Lync Meeting for September 24, 2014, to train local WCP staffs on the processes to evaluate, refer and follow-up on potential fraud referrals.

OIG CHALLENGE #4: PROCUREMENT PRACTICE
-Strategic Overview-

VA operations require the efficient procurement of a broad spectrum of services, supplies, and equipment at national and local levels. OIG audits and reviews continue to identify systemic deficiencies in all phases of the procurement process, including planning, solicitation, negotiation, award, and administration. OIG attributes these deficiencies to inadequate oversight and accountability.

Recurring systemic deficiencies in the procurement process, including the failure to comply with the Federal Acquisition Regulation and VA Acquisition Regulation, and the lack of effective oversight increase the risk that VA may award contracts that are not in the best interest of the Department. Further, VA risks paying more than fair and reasonable prices for supplies and services and making overpayments to contractors. VA must improve its acquisition processes and oversight to ensure the efficient use of VA funds and compliance with applicable acquisition laws, rules, regulations, and policies.

VA uses a Strategic Capital Investment Plan (SCIP) to prioritize its major construction, minor construction, non-recurring maintenance, and lease projects. SCIP's objective is to produce an annual consolidated list of capital projects that significantly reduce identified performance gaps in Veterans' access, workload and utilization, safety, space, and facility conditions over a 10-year period. SCIP is used to ensure that VA's strategic performance planning efforts address the needs of VA's three Administrations—VHA, VBA, and NCA.

The OIG has completed reviews that disclosed a pattern of ineffective VA capital planning and asset management. OIG reports have shown that VA has not effectively executed authorized construction and lease projects to ensure they are completed on-time and within budget.   For example, VA lacks assurance that it is timely and cost-effectively acquiring health care facilities to serve the needs of its Veteran population. Further, VA has not effectively managed the capital asset planning process to ensure that minor construction projects are not combined or otherwise significantly changed after approval.

OIG Sub-Challenge #4A: Improving Health Care Center Leasing (OALC, VHA)

In October 2013, OIG reported in its *Review of VA's Management of Health Care Center Leases* that VA's management of timeliness and costs in the Health Care Center (HCC) lease procurement process was ineffective. As of August 2013, only four of seven leases had been awarded and no HCCs had been built, despite VA's target completion date of June 2012. Congress authorized approximately $150 million for the HCC facility activations. OIG found the following deficiencies:

- Lack of Guidance – VA did not meet the aggressive milestones it set for HCC activation and occupancy due to a lack of specific guidance for this new initiative. The existing VA handbook did not cover lease projects with such high annual costs as those of the new HCCs.
- Inaccurate Milestones – VA used identical milestones for completing the seven HCCs even though the projects varied in size and budget. VA planned 32 total months for completing the   seven HCCs, with annual lease costs ranging from $3.8 million to $16.2 million. Also, VA used a two-step process that separated land acquisition and contractor selection into different phases and should have lengthened each overall lease acquisition by 8 to 9 months.
- Lack of Documentation – Documentation was unavailable to support whether VA adequately assessed the feasibility of accomplishing the HCCs in the aggressive 32-month time frame promised. Given the lack of progress to date and the inadequate planning documentation, it will take far more time than Congress anticipated for VA to award and activate the seven leases.
- Lack of Central Tracking – VA could not provide accurate information on HCC spending into April 2013. According to VA officials, central cost tracking was not in place to ensure transparency and accurate reporting on all HCC expenditures. During OIG audit work, VA officials provided various estimates, ranging from about $4.6 million to $5.1 million, on the costs to prepare for HCC lease awards, but there was not sufficient evidence to provide reasonable assurance that this figure represents a complete accounting of HCC costs. Until effective central cost tracking is instituted, expenditures to acquire the HCC leases will remain unclear.

OIG made recommendations to establish adequate guidance for management of the procurement process of large-scale build-to-lease facilities, provide realistic and justifiable timelines for HCC completion, ensure HCC project analyses and key decisions are supported and documented, and establishment of central cost tracking to ensure transparency and accurate reporting on HCC expenditures.

VA's Program Response
Estimated Resolution Timeframe: 2014
Responsible Agency Official: Principal Executive Director, OALC/Under Secretary for Health, VHA

Completed Fiscal Year 2014 Milestones

Beginning in FY 2015, all leases including Health Care Center leases, regardless of expansion amount, are required to be submitted through SCIP process. This Department-wide SCIP process was developed to improve the capital planning process with the goal of improving the delivery of services and benefits to Veterans, of investing in VA's future, and of improving the efficiency of operations. This process integrates various capital investment planning efforts in VA for all of the following: 1) Major Construction, 2) Minor Construction, 3) Leasing, which includes all new or renewal medical, non-medical, program office leases [of any annual cost and/or square footage], Vet Centers [regardless of the funding source or their delegated authorities], 4) VHA Non-Recurring Maintenance, 5) NCA Non-Recurring Maintenance, 6) Enhanced-Use Leasing, and 7) Sharing or other formal Agreements.

Non-capital solutions to gaps are also included in the process requiring a brief description in the Strategic Capital Assessment and a designation of that type of solution in the Action Plan only. The end result is a long-range plan of capital investments and resource levels needed that are based on gaps identified at the corporate level (top-down) and at the local level (bottom-up) across the Department. SCIP is fully integrated into VA Planning, Programming, Budgeting, and Evaluation process. This strategic planning approach conforms to established 2015 budget deadlines. The SCIP process is robust, transparent, and data-driven, resulting in a fully integrated prioritized listing of all proposed capital investments that are tied to the VA Strategic Plan. This process is designed to capture the full extent of VA infrastructure and service gaps and the resources needed to address the deficiencies and gaps. Planning is based on finding the ideal way to deliver services while considering the reality of current locations. The SCIP process employs two main components: action plans – which include a gap analysis, strategic capital assessment, and long-range capital plan – and business cases. Strategic capital assessments and long-range capital plans are evaluated by senior VA officials. Projects approved for 2015 require business cases for prioritization purposes.

In addition to the SCIP process, VHA directed VA Medical Center Chief Engineers to request Lease Accounting Classification Codes for all SCIP approved leases for purposes of central cost tracking and reporting on HCC expenditures.

The Office of Acquisition, Logistics and Construction (OALC), continues to work update the Lease Based Outpatient Clinic Design Guide (LBOPCDG), which now contains specific narrative guidance on large-scale, build-to-suit leased facilities. OALC anticipates that the LBOPCDG update will be published by the end of Fiscal Year 2014.

Additionally, Veterans Affairs Handbook 7815, Acquisition of Real Property by Lease and by Assignment from the General Services Administration, is in process of being updated to provide the most current guidance available for the leasing process and it is anticipated it be published by the end of Fiscal Year 2014.

OALC evaluated the project schedules and re-baselined them, creating Integrated Master Schedules (IMSs) that provide realistic timeframes to accompany lease milestones. These time lines were first presented in the VA Fiscal Year 2014 Budget submission and will continue to be refined. These schedules include the flexibility for one-step or two-step procurements with all associated milestones. The LBOPCDG will also contain lease milestones and the formalization of the process for selecting a one-step vs two-step procurement already being used for prospectus projects. VA will develop project-specific IMSs that utilize the milestone durations and will adhere to these from procurement inception until the first patient is seen.

The General Services Administration (GSA) rescinded VA's blanket delegation of authority to lease in July 2014. All VA leases, regardless of size, scope, or Congressional authorization as required by 38 USC 8103, now require individual delegations of authority from GSA. However, GSA's inability to delegate leases above its current Prospectus threshold of $2.85M may lead to further delays in bringing these much needed projects to fruition and may require multiple short-term, smaller leases to bridge the gap between expiring and new facilities, especially those not-yet-delegated by GSA.

Publication of the LBOPCDG may be delayed pending the final outcome of the lease delegation of authority to include any new required processes or procedures.

OIG Sub-Challenge #4B: Improving Oversight of Minor Construction Projects (VHA)

In OIG's December 2012 report *Review of VHA's Minor Construction Program*, OIG reviewed the organizational structure, procedures, and financial controls VHA used to manage its minor construction projects. OIG reported that VHA's Minor Construction Program lacked adequate internal controls for oversight of individual projects as a means of ensuring proper use of minor construction funds. OIG found that VHA did not ensure that medical facility funding was consistently used to supplement minor construction projects. In addition, VHA did not ensure adequate monitoring of minor construction project schedules and expenditures.

VHA integrated design and construction work for 7 of 30 minor construction projects into 3 combined projects that exceeded the $10 million minor construction spending limit. As a result, OIG reported that VHA violated the Anti-Deficiency Act in five of seven projects. OIG also found that 3 of 30 projects were inappropriately supplemented with medical facility funds and project monitoring was ineffective. A third combined project was in the process of being awarded; however, when the OIG notified VHA of a

potential Anti-Deficiency Act violation, VHA suspended these projects during the award process. This improper use of minor construction funding occurred because Office of Capital Asset Management and Support (OCAMS) and VISN officials did not effectively oversee project execution and OCAMS fully funded individual projects prior to medical facilities developing contract solicitations for design and construction.

Once funding was provided to medical facilities, OCAMS and VISNs were dependent on the facilities to self-report changes in project scope during the contract solicitation process. This resulted in OCAMS and VISNs not being fully aware of project scope changes in the contract solicitation process for design and construction. According to an OCAMS official, VHA was strongly encouraged to outsource design and construction contract management to the U.S. Army Corps of Engineers (USACE) at medical facilities where contracting resources were scarce. USACE managed 13 of the 30 projects reviewed.

Typically, after OCAMS officials approved minor construction projects, USACE managed project execution. USACE was responsible for integrating the design and construction of five of the seven minor construction projects identified as being improperly combined into two major construction projects. According to VHA officials, OCAMS maintained no control over project scope once funding was allotted and did not even review the construction contract solicitation prepared by the USACE's contracting officer. Further, at one VA medical facility, project engineers responsible for the facility's minor construction projects did not have copies of the USACE contracts signed on the medical facility's behalf. This condition heightened construction risks and limited oversight and control of construction costs and change orders.

OIG's report on medical facility funding and minor construction projects also disclosed that 3 of the 30 minor construction projects reviewed were supplemented with medical facility funding. These three projects received $24.4 million in minor construction and $14.6 million from medical facility funds. When adding funding from both appropriations together, two of the three projects exceeded the $10 million spending limit for minor construction projects. VA medical facilities did not follow non-recurring maintenance (NRM) policy limiting the use of medical facility funding to supplement minor construction projects and limiting renovation projects to $500,000. OCAMS provided guidance in September 2008 and again in September 2010 to VA medical facilities on the allowable uses of minor construction and NRM funds based on draft handbooks that had not been officially issued.

These draft handbooks defined the limits of minor construction projects and expanded NRM to include projects that renovated and modernized existing facility square footage between $500,000 and $10 million. OCAMS and VISN officials did not routinely monitor minor construction project schedules and financial performance. Rather, OCAMS assigned responsibility to VA medical facility project engineers to monitor the projects and notify OCAMS if significant changes occurred or additional project funding was required. The draft minor construction program handbook required OCAMS to create

Minor Program Review Teams to perform quarterly reviews of project schedules and financial performance at selected sites. However, OIG found no evidence that the Minor Program Review Teams were formed or that internal program reviews were performed. As a result, VHA lacked the ability to effectively identify projects with cost overruns, significant schedule slippages, or significant construction scope changes in a timely manner and take corrective actions when necessary.

OIG recommended the USH publish Minor Construction Program policy, develop procedures to ensure projects are executed within their approved scope, and determine whether other combined minor construction projects violated the Anti-Deficiency Act. VHA also needed to implement a mechanism to ensure medical facility funding is not used to supplement minor construction projects, ensure program reviews are performed, and strengthen project tracking reports. Without effective capital asset management, VA officials have not been able to ensure authorized leased projects are completed timely and within budget, minor construction projects are not combined or otherwise significantly changed after approval, leased facilities are the right size and the right location to ensure they are fully utilized once completed, or authorized lease projects are completed timely and within budget. Until these issues are addressed, VA will continue to lack assurance that it is timely and cost-effectively acquiring health care facilities to serve the needs of Veterans.

VA's Program Response
Estimated Resolution Timeframe: 2014
Responsible Agency Official: Under Secretary for Health

Completed Fiscal Year 2014 Milestones

In November 2012, VHA Office of Capital Asset Management Engineering and Support (OCAMES) published VHA Handbook 1002.02, *Minor Construction Program*, which establishes the procedures and responsibilities for the management of the Minor Construction Program.

In the past two years, OCAMES has expanded its service to VHA facilities by establishing the compliance team of engineering personnel to assist the Capital Support section in performing site visits and working closely with facilities on construction projects. To ensure minor construction projects are executed within their approved scope, VHA's OCAMES has begun reviewing all minor construction design or construction funding transaction requests, comparing the latest design or construction documents to approved scopes of work based on the approved application or change in scope memo prior to funding transaction request approval.

In addition, beginning in fiscal year 2014, the OCAMES added a new Veterans Integrated Service Network (VISN) Director Performance Measure to ensure that Project Tracking Reports are updated monthly, as appropriate. These reports are also

being shared with VISN Capital Asset Managers on a monthly basis to ensure a proactive stance in managing outlier issues and missing data.

OCAMES ensures medical facility funding is not used to supplement minor construction projects. This has been done by a team approach with the Minor Construction Program Manager and the Capital Support section, which routinely review high risk minor construction projects greater than $9.5 million, NRM and Clinical Specific Initiative (CSI) projects with similar titles, and minor construction projects contracted to the Army Corps of Engineers. If augmentation is identified, appropriate corrective actions are instructed to the VISN and medical center staff. If appropriation or authorization violations appear to have occurred, the OCAMES Director sends the report to Office of General Counsel (OGC) for an official opinion and follow-up action.

With respect to Office of Inspector General Report 12-03346-69, *Review of the Minor Construction Program* (December 2012), OCAMES staff reviewed the seven potentially problematic minor construction projects to assess whether projects were combined into major construction projects. As a result of this review, OCAMES has worked with OGC, VISN and facility staff to provide guidance and consultation to ensure that six of the seven projects identified did not exceed the $10 million Minor Construction threshold. VHA identified that a violation on one of the projects did occur, and will take appropriate action.

OIG CHALLENGE #5: INFORMATION MANAGEMENT
-Strategic Overview-

The use of information technology (IT) is critical to VA providing a range of benefits and services to Veterans, from medical care to compensation and pensions. If managed effectively, IT capital investments can significantly enhance operations and support the secure and effective delivery of VA benefits and services. However, when VA does not properly plan and manage its IT investments, they can become costly, risky, and counterproductive. Lacking proper safeguards, computer systems also are vulnerable to intrusions by groups seeking to obtain sensitive information, commit fraud, disrupt operations, or launch attacks against other systems.

Under the leadership of the Executive in Charge of Information and Technology, VA's Office of Information and Technology (OIT) is positioning itself to facilitate VA's transformation into a 21st century organization through improvement strategies in five key IT areas: (1) quality customer service, (2) continuous readiness in information security, (3) transparent operational metrics, (4) product delivery commitments, and (5) fiscal management. OIT's efforts are also focused on helping accomplish VA's top three agency priority goals of expanding access to benefits and services, eliminating the claims backlog in 2015, and ending Veteran homelessness in 2015.

However, OIG oversight work indicates that additional actions are needed to effectively manage and safeguard VA's information resources and processing operations. As a result of the FY 2013 CFS audit, OIG's independent auditor reported that VA did not substantially comply with requirements of the Federal Financial Management Improvement Act of 1996. While providing an unqualified opinion on the CFS, the independent auditor has identified IT security controls as a material weakness.

OIG work indicates VA has only made marginal progress toward eliminating the material weakness and remediating major deficiencies in IT security controls. VA could not readily account for the various systems linkages and sharing arrangements with affiliate organizations, leaving sensitive Veterans' data at unnecessary risk of unauthorized access and disclosure. OIT also has not fully implemented competency models, identified competency gaps, or created strategies for closing the gaps to ensure its IT human capital resources will support VA in accomplishing IT initiatives and mission goals well into the future. Despite implementation of the Program Management and Accountability System (PMAS) to ensure oversight and accountability, VA is still challenged in effectively managing its IT systems initiatives to maximize the benefits and outcomes from the funds invested.

OIG Sub-Challenge #5A: Develop an Effective Information Security Program and System Security Controls (OIT)

Secure systems and networks are integral to supporting the range of VA mission-critical programs and operations. Information safeguards are essential, as demonstrated by well-publicized reports of information security incidents, the wide availability of hacking tools on the internet, and the advances in the effectiveness of attack technology. In several instances, VA has reported security incidents in which sensitive information has been lost or stolen, including personally identifiable information (PII) — exposing millions of Americans to the loss of privacy, identity theft, and other financial crimes. The need for an improved approach to information security is apparent, and one that senior Department leaders recognize. Recent work on the CFS audit supports OIG's annual Federal Information Security Management Act (FISMA) assessment. During FY 2013, VA continued to implement its Continuous Readiness in Information Security Program to ensure continuous monitoring year-round and establish a team responsible for resolving the IT material weakness. In August 2013, VA also implemented an IT Governance, Risk and Compliance Tool to improve the process for assessing, authorizing, and monitoring the security posture of the agency. As FISMA work progressed, OIG noted more focused VA efforts to implement standardized information security controls across the enterprise. OIG also saw improvements in role-based and security awareness training, contingency plan testing, reduction in the number of outstanding Plans of Action and Milestones (POA&M), development of initial baseline configurations, reduction in the number of IT individuals with outdated background investigations, and improvement in data center web application security.

However, these controls require time to mature and show evidence of their effectiveness. Accordingly, OIG continues to see information system security deficiencies similar in type and risk level to our findings in prior years and an overall inconsistent implementation of the security program. Moving forward, VA needs to ensure a proven process is in place across the agency. VA also needs to continue to address control deficiencies that exist in other areas across all VA locations. OIG continues to find control deficiencies in Security Management, Access Controls, Configuration Management, and Contingency Planning. Most importantly, OIG continues to identify significant technical weaknesses in databases, servers, and network devices that support transmitting financial and sensitive information between VAMCs, VA Benefit Offices, and Data Centers. This is a result of an inconsistent application of vendor patches that could jeopardize the data integrity and confidentiality of VA's financial and sensitive information.

VA has made progress in deploying current patches; however, older patches and previously identified vulnerabilities continue to persist on networks. Even though VA has made some progress in these areas, more progress must be made to improve deployment of patches that will mitigate security vulnerabilities and to implement a centralized process that is consistent across all field offices. Many of these weaknesses can be attributed to an inconsistent enforcement of an agency-wide information security program across the enterprise and ineffective communication between VA management and the individual field offices. Therefore, VA needs to improve its performance monitoring to ensure controls are operating as intended at all facilities and communicate security deficiencies to the appropriate personnel, who will implement corrective actions.

As such, the FY 2013 FISMA audit report discussed control deficiencies in four key areas: (1) configuration management controls, (2) access controls, (3) change management, and (4) service continuity controls. Improvements are needed in these key controls to prevent unauthorized access, alteration, or destruction of major application and general support systems. VA had over 6,000 system security risks and corresponding POA&Ms that still need to be remediated to improve its overall information security posture. More importantly, OIG continued to identify significant technical weaknesses in databases, servers, and network devices that support transmitting sensitive information among VA facilities. Many of these weaknesses may be attributed to inconsistent enforcement of an agency-wide information security program across the enterprise and ineffective communication between VA management and the individual field offices.

OIG's FY 2013 FISMA report provided 30 current recommendations to the Executive in Charge of Information and Technology for improving VA's information security program. The report also highlighted 5 unresolved recommendations from prior years' assessments for a total of 35 outstanding recommendations. Overall, OIG recommended that VA focus its efforts in the following areas:

- Addressing security-related issues that contributed to the IT material weakness reported in the FY 2013 Consolidated Financial Statements Audit of the Department.
- Successfully remediating high-risk system security issues in its POA&Ms.
- Establishing effective processes for evaluating information security controls via continuous monitoring and vulnerability assessments.

OIG continues to evaluate VA's progress during the ongoing FY 2014 FISMA audit and acknowledges increased VA efforts to improve information security, but OIG is still identifying repeat deficiencies, albeit to a lesser extent. Upon completion of the FY 2014 FISMA testing and related work, OIG will make a determination as to whether VA's improvement efforts are successful in overcoming the IT material weakness.

A range of additional OIG audits and reviews over the past 2 years have exemplified VA's information security controls deficiencies. For example, in March 2013, the OIG reported that VA was transmitting sensitive data, including PII and internal network routing information, over an unencrypted telecommunications carrier network. VA OIT personnel disclosed that VA typically transferred unencrypted sensitive data, such as EHRs and internal Internet protocol addresses, among certain VAMCs and CBOCs using an unencrypted telecommunications carrier network. OIT management acknowledged this practice and formally accepted the security risk of potentially losing or misusing the sensitive information exchanged. VA has not implemented technical configuration controls to ensure encryption of sensitive data despite VA and Federal information security requirements. Without controls to encrypt the sensitive VA data transmitted, Veterans' information may be vulnerable to interception and misuse by malicious users as it traverses unencrypted telecommunications carrier networks. Further, malicious users could obtain VA router information to identify and disrupt mission-critical systems essential to providing health care services to Veterans.

Further, in February 2012, OIG reported that VA did not adequately protect sensitive data hosted within its System-to-Drive-Performance (STDP) application. Specifically, OIG determined that more than 20 system users had inappropriate access to sensitive STDP information. Further, OIG reported that project managers did not report unauthorized access as a security event as required by VA policy. STDP project managers were not fully aware of VA's security requirements for system development and had not formalized user account management procedures. Inadequate Information Security Officer oversight contributed to weaknesses in user account management and failure to report excessive user privileges as security violations. As a result, VA lacked assurance of adequate control and protection of sensitive STDP data. VA OIT plans to implement a VA-wide encryption solution to mitigate these security risks.

In July 2011, OIG reported that certain contractors did not comply with VA information security policies for accessing mission critical systems and networks. For instance, contractor personnel improperly shared user accounts when accessing VA networks and systems, did not readily initiate actions to terminate accounts of separated

employees, and did not obtain appropriate security clearances or complete security training for access to VA systems and networks. OIG concluded that VA has not implemented effective oversight to ensure that contractor practices comply with its information security policies and procedures. Contractor personnel also stated they were not aware of VA's information security requirements. As a result of these deficiencies, VA sensitive data is at risk of inappropriate disclosure or misuse.

An effective information security program and adequate system security controls also includes limiting employee or contractor access to sensitive information to only that which is needed to accomplish the mission and perform his or her job. For example, a scheduling clerk whose duties involve contacting a Veteran to verify or schedule an appointment may require only the patient's name, phone or email contact information, and the date and nature of the appointment to schedule an appointment and notify the Veteran. OIG has initiated multiple criminal investigations of VA employees who are suspected of having sold sensitive personal information about Veteran patients to which they had access to individuals who used this information to file bogus electronic tax returns and obtain fraudulent refunds. To date, 10 individuals have been arrested, 12 individuals have been indicted, and 7 individuals have been convicted regarding schemes in which the identities of Veterans were stolen from VA. These cases have resulted in over $5.7 million in fraudulent tax returns. VA data managers need to be cognizant of the potential for misuse of sensitive information and limit its access by VA employees to the minimum necessary to conduct business. VA also has a duty to ensure proper handling and destruction of VA documents containing PII to ensure that these documents are not exposed to the possibility of theft. OIG has provided one management implication notification to VA management on this issue.

VA's Program Response
Estimated Resolution Timeframe: 2015
Responsible Agency Official: Executive in Charge and Chief Information Officer

Completed 2014 MMC Milestones:

OIT continued efforts to improve VA's information security program and system security controls throughout 2014 by addressing findings in the 2013 Federal Information Security Management Act (FISMA) Report regarding configuration management, access controls, change management, and service continuity controls. VA has made progress in managing Plans of Action and Milestones (POA&Ms), in part, by our continuing initiatives such as the Governance, Risk, and Compliance (GRC) tool, Agiliance RiskVision OpenGRC (RiskVision), which establishes effective processes for evaluating information security controls through continuous monitoring across the VA network. This tool automatically ties risk assessments to POA&Ms and system security plans, resulting in a more comprehensive understanding of VA's security posture.

Regarding the OIG finding that significant technical weaknesses were identified in databases, servers, and network devices that transmit sensitive information, VA is now working to modernize security standards on servers and network devices. This past quarter the Chief Information Security Officer issued a memorandum requiring the use of Defense Information Systems Agency (DISA) Standard Technical Guides (STIGs) and the United States Government Configuration Baseline (USGCB) baseline.

VA purchased encryption software licenses with the anticipation of encrypting both desktop and laptop computers. VA has deployed Windows 7 with encryption across the enterprise, and was also the first government agency to implement CERT Intrusion Prevention Security Services (IPSS), also known as Einstein III, which provides monitoring and prevention against cyber threats.

OIG asserted that inconsistent application of vendor patches could jeopardize the data integrity and confidentiality of VA's information. While VA acknowledges that patches are sometimes applied differently, depending upon each system's unique functionality, it is important to point out that VA only deploys patches that are determined not to pose operational threats to our mission delivery of patient care and services to Veterans while ensuring maximum protection of Veterans' data.

To address the finding that VA needs to improve its performance monitoring to ensure controls are operating as intended, we have shifted to real-time continuous monitoring, allowing us to assess demand and address any significant risk to our systems and devices. For example, we are starting to leverage automated scanning results and continuous monitoring data when evaluating system and network security risk and when making risk decisions for the VA enterprise. VA also implemented Trusted Internal Connections (TIC) to enhance monitoring and awareness of external connections. In response to the finding that employee and contractor access to sensitive information should be limited only to that which is needed for job duties, VA continues to implement, follow, and enforce Elevated Privilege Review which grants access for sensitive information only to users who need it for their job duties. Employees are required annually to sign the Rules of Behavior and complete information security and privacy awareness training.

APPENDIX

The Appendix lists selected reports pertinent to the five key challenges discussed. However, the Appendix is not intended to encompass all OIG work in an area.

OIG MAJOR MANAGEMENT CHALLENGE #1: HEALTH CARE DELIVERY

Healthcare Inspection–Emergency Department Staffing and Patient Safety Issues, VA San Diego Healthcare System, San Diego, California
9/3/2014 | 14-00271-265 | Summary |

Healthcare Inspection–Follow-up Review of the Pause in Providing Inpatient Care VA Northern Indiana Healthcare System, Fort Wayne, Indiana
8/28/2014 | 13-00670-262 | Summary |

Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System
8/26/2014 | 14-02603-267 | Summary |

Healthcare Inspection–Deficiencies in the Caregiver Support Program, Ralph H. Johnson VA Medical Center, Charleston, South Carolina
8/21/2014 | 14-00991-255 | Summary |

Healthcare Inspection–Coordination and Delivery of Medical Care Concerns, VA Black Hills Health Care System, Fort Meade, South Dakota
8/20/2014 | 14-01467-256 | Summary |

Healthcare Inspection–Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, GA
8/12/2014 | 14-03010-251 | Summary |

Healthcare Inspection–Quality of Care and Staff Safety Concerns at the Huntsville Community Based Outpatient Clinic, Huntsville, Alabama
7/17/2014 | 14-01322-215 | Summary |

Healthcare Inspection–Alleged Medication Cart Deficiencies and Unsafe Medication Administration Practices, Atlanta VA Medical Center, Decatur, Georgia
7/16/2014 | 14-02396-212 | Summary |

Healthcare Inspection–Reporting of Suspected Patient Neglect, Central Alabama Veterans Health Care System, Tuskegee, Alabama
7/16/2014 | 14-02903-211 | Summary |

Healthcare Inspection–Alleged Mismanagement in the Cardiac Catheterization Laboratory, VA Maryland Health Care System, Baltimore, Maryland
7/15/2014 | 13-02892-217 | Summary |

Healthcare Inspection–Alleged Surgical Care Issues, Malcom Randall VA Medical Center, Gainesville, Florida
7/14/2014 | 14-00992-210 | Summary |

Healthcare Inspection–Potential Exposure to Creutzfeldt-Jakob Disease, VA Connecticut Healthcare System, West Haven, Connecticut
7/1/2014 | 13-04520-201 | Summary |

Healthcare Inspection–Substandard Care of a Lupus Patient at the Albany CBOC and Carl Vinson VA Medical Center, Dublin, Georgia
7/1/2014 | 14-00467-202 | Summary |

Healthcare Inspection–Medication Management Issues in a High Risk Patient, Tuscaloosa VAMC, Tuscaloosa, Alabama

6/25/2014 | 13-02665-197 | Summary |

Healthcare Inspection–Resident Supervision in the Operating Room, Ralph H. Johnson VA Medical Center, Charleston, South Carolina

6/23/2014 | 14-00637-199 | Summary |

Healthcare Inspection–Quality of Care and Staffing Concerns, Salem VA Medical Center, Salem, Virginia

6/23/2014 | 13-03604-198 | Summary |

Healthcare Inspection–Follow-Up of Mental Health Inpatient Unit and Outpatient Contract Programs, Atlanta VA Medical Center, Decatur, Georgia

6/19/2014 | 12-03869-187 | Summary |

Healthcare Inspection–Alleged Preventive Maintenance Inspection Deficiencies, Northern Arizona VA Health Care System, Prescott, Arizona

6/9/2014 | 13-04592-179 | Summary |

Healthcare Inspection–Quality of Care Concerns, Hospice/Palliative Care Program, VA Western New York Healthcare System, Buffalo, New York

6/9/2014 | 13-04195-180 | Summary |

Healthcare Inspection–Community Living Center Patient Care, Gulf Coast Veterans Health Care System, Biloxi, Mississippi

5/28/2014 | 14-01119-168 | Summary |

Interim Report: Review of VHA's Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System

5/28/2014 | 14-02603-178 | Summary |

Healthcare Inspection–GI Fellowship Program Issues, New Mexico VA Health Care System, Albuquerque, New Mexico

5/23/2014 | 14-00612-167 | Summary |

Healthcare Inspection–Podiatry Clinic Staffing Issues and Delays in Care, Central Alabama Veterans Health Care System, Montgomery, Alabama

5/19/2014 | 13-04474-157 | Summary |

Audit of VHA's Mobile Medical Units

5/14/2014 | 13-03213-152 | Summary |

Healthcare Inspection–VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy

5/14/2014 | 14-00895-163 | Summary |

Healthcare Inspection–Improper Procurement and Billing Practices for Anesthesiology Services, George E. Wahlen VA Healthcare System, Salt Lake City, Utah

5/6/2014 | 13-01819-133 | Summary |

Healthcare Inspection–Alleged Excessive Wait for Emergency Care and Staff Disrespect, VA Southern Nevada Healthcare System, Las Vegas, Nevada

4/30/2014 | 14-01104-134 | Summary |

Healthcare Inspection–Questionable Cardiac Interventions and Poor Management of Cardiovascular Care, Edward Hines, Jr. VA Hospital, Hines, Illinois

4/8/2014 | 13-02053-119 | Summary |

Healthcare Inspection–Administrative Irregularities, Leadership Lapses, and Quality of Care Concerns, VA Central Iowa Health Care System, Des Moines, Iowa

3/31/2014 | 13-02073-106 | Summary |

Healthcare Inspection–Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, Florida
3/27/2014 | 13-03089-104 | Summary |

Alleged Adverse Outcomes and Access Issues in Diagnostic Imaging Services, North Florida/South Georgia Veterans Health System, Gainesville, Florida
3/20/2014 | 13-00853-100 | Summary |

Audit of VA's Hearing Aid Services
2/20/2014 | 12-02910-80 | Summary |

Healthcare Inspection–Environment of Care Deficiencies in the Operating Room, VA Connecticut Healthcare System, West Haven, Connecticut
2/18/2014 | 13-03747-76 | Summary |

Healthcare Inspection–Alleged Patient Safety Concerns in the Operating Room, VA Maine Healthcare System, Augusta, Maine
2/12/2014 | 13-03624-58 | Summary |

Healthcare Inspection–Alleged Lapses in Communication and Poor Quality of Care, Charlie Norwood VA Medical Center, Augusta, Georgia
2/12/2014 | 13-03178-70 | Summary |

Healthcare Inspection–Quality of Care, Management Controls, and Administrative Operations, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina
2/6/2014 | 13-00872-71 | Summary |

Healthcare Inspection–Quality of Care Issues, San Juan VA Medical Center, San Juan, Puerto Rico
12/30/2013 | 13-01956-37 | Summary |

Healthcare Inspection–Emergency Department Length of Stay and Call Center Wait Times, VA Eastern Colorado Health Care System, Denver, Colorado
12/23/2013 | 13-03862-35 | Summary |

Healthcare Inspection–Alleged Chemotherapy Delay and Excessive Emergency Department Length of Stay, Jesse Brown VA Medical Center, Chicago, Illinois
12/9/2013 | 13-00488-26 | Summary |

Healthcare Inspection–Alleged Computed Tomography Scan Delays and Timekeeping Abuses, Dayton VA Medical Center, Dayton, Ohio
11/20/2013 | 12-04061-18 | Summary |

Healthcare Inspection–Alleged Improper Opioid Prescription Renewal Practices, San Francisco VA Medical Center, San Francisco, California
11/7/2013 | 13-00133-12 | Summary |

Healthcare Inspection–Audiology Staffing, Consult Management, and Access to Care, Sheridan VA Healthcare System, Sheridan, Wyoming
11/5/2013 | 13-03670-13 | Summary |

Healthcare Inspection–Emergency Department Patient Deaths' Memphis VAMC, Memphis, Tennessee
10/23/2013 | 13-00505-348 | Summary |

Congressional Testimony 9/17/2014
Statement of Richard J. Griffin Acting Inspector General Office of Inspector General Department of Veterans Affairs Before The Committee On Veterans' Affairs United States House of Representatives Hearing On "Scheduling Manipulation And Veteran Deaths In Phoenix: Examination of the OIG's Final Report" More

Congressional Testimony 9/17/2014
Oral Statement of Richard J. Griffin Acting Inspector General Office of Inspector General Department of Veterans Affairs Before The Committee On Veterans' Affairs United States House Representatives Hearing On "Scheduling Manipulation And Veteran Deaths In Phoenix: Examination of the OIG's Final Report" More

Congressional Testimony 6/9/2014
Statement of Richard J. Griffin Acting Inspector General Office of Inspector General Department of Veterans Affairs Before the Committee On Veterans' Affairs United States House of Representatives Oversight Hearing On "Data Manipulation And Access To VA Healthcare: Testimony From GAO, IG, and VA" More

Congressional Testimony 5/29/2014
Statement of Linda A. Halliday Assistant Inspector General for Audits and Evaluations Office of Inspector General Department of Veterans Affairs Before the Subcommittee on Disability Assistance and Memorial Affairs Committee on Veterans' Affairs United States House of Representatives Hearing on "Defined Expectations: Evaluating VA's Performance in the Service Member Transition Process" More

Congressional Testimony 5/15/2014
Statement of Richard J. Griffin Acting Inspector General Office of Inspector General Department of Veterans Affairs Before Committee On Veterans' Affairs United States Senate Hearing On "The State of VA Health Care" More

Congressional Testimony 5/15/2014
Oral Statement of Richard J. Griffin Acting Inspector General Office of Inspector General Department of Veterans Affairs Before Committee On Veterans' Affairs United States Senate Hearing On "The State of VA Health Care" More

Congressional Testimony 4/9/2014
Statement of John D. Daigh, Jr., M.D. Assistant Inspector General For Healthcare Inspections Office of Inspector General Department of Veterans Affairs Before Committee on Veterans' Affairs United States House Of Representatives Hearing On "A Continued Assessment of Delays in VA Medical Care and Preventable Veteran Deaths" More

OIG CHALLENGE #2: BENEFITS PROCESSING

Review of Alleged Data Manipulation at the VA Regional Office Houston, TX
9/30/2014 | 14-04003-298 | Summary |

Review of Alleged Data Manipulation at the Los Angeles VA Regional Office
9/18/2014 | 14-03736-273 | Summary |

Audit of VBA's Efforts to Effectively Obtain Veterans' Service Treatment Records
8/28/2014 | 14-00657-261 | Summary |

Review of Alleged Mail Mismanagement at VBA's Baltimore VA Regional Office
7/14/2014 | 14-03644-225 | Summary |

Review of VBA's Special Initiative To Process Rating Claims Pending Over 2 Years
7/14/2014 | 13-03699-209 | Summary |

Audit of NCA's Rural Veterans Burial Initiative
7/14/2014 | 13-03468-203 | Summary |

Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments
7/11/2014 | 13-01452-214 | Summary |

Follow-Up Audit of VHA's Workers' Compensation Case Management
7/7/2014 | 11-00323-169 | Summary |

Follow-up Audit of VBA's 100 Percent Disability Evaluations
6/6/2014 | 14-01686-185 | Summary |

Audit of VBA's Management of Concurrent VA and Military Drill Pay Compensation
6/3/2014 | 13-02129-177 | Summary |

Review of Alleged Mismanagement of VBA's Eastern Area Fiduciary Hub
5/28/2014 | 13-03018-159 | Summary |

Audit of the Quick Start Program
5/20/2014 | 12-00177-138 | Summary |

Interim Report - VBA's Efforts to Effectively Obtain Service Treatment Records and Official Military Personnel Files
5/15/2014 | 14-00657-144 | Summary |

Audit of VHA's Supportive Services for Veteran Families Program
3/31/2014 | 13-01959-109 | Summary |

Congressional Testimony 7/14/2014
Statement of Linda A. Halliday Assistant Inspector General for Audits and Evaluations Office of Inspector General Department of Veterans Affairs Before The Committee on Veterans' Affairs United States House Of Representatives Hearing On "Evaluation Of The Process To Achieve VBA Goals" More

Congressional Testimony 12/4/2013
Statement of Sondra F. McCauley Deputy Assistant Inspector General For Audits And Evaluations Office of Inspector General, Department of Veterans Affairs Before The Subcommittee On Disability Assistance And Memorial Affairs Committee On Veterans'

Affairs United States House Of Representatives Hearing On "Adjudicating VA's Most Complex Disability Claims: Ensuring Quality, Accuracy, And Consistency On Complicated Issues" More

OIG CHALLENGE #3:   FINANCIAL MANAGEMENT
VA's Federal Information Security Management Act Audit for Fiscal Year 2013
5/29/2014 | 13-01391-72 | Summary |
FY 2013 Review of VA's Compliance With the Improper Payments Elimination and Recovery Act
4/15/2014 | 13-02926-112 | Summary |
Independent Review of VA's FY 2013 Performance Summary Report to the Office of National Drug Control Policy
2/11/2014 | 14-00257-67 | Summary |
Independent Review of VA's FY 2013 Detailed Accounting Submission to the Office of National Drug Control Policy
2/10/2014 | 14-00258-66 | Summary |
Audit of VA's Consolidated Financial Statements for FY's 2013 and 2012
11/27/2013 | 13-01316-22 | Summary |

OIG CHALLENGE #4:   PROCUREMENT PRACTICE
Review of Alleged Unauthorized Commitments Within VA
5/21/2014 | 13-00991-154 | Summary |
Audit of the Non-Recurring Maintenance Program
5/7/2014 | 13-00589-137 | Summary |
Audit of VHA's Engineering Service Purchase Card Practices at the Ralph H. Johnson VAMC, Charleston, SC
4/17/2014 | 13-02267-124 | Summary |
Review of the Lease Awarded to Westar Development Company, LLC for the Butler, Pennsylvania Health Care Center
3/31/2014 | 13-02697-113 | Summary |
Review of VA's Management of Health Care Center Leases
10/22/2013 | 12-04046-307 | Summary |

Congressional Testimony 11/20/2013
Statement of Linda A. Halliday Assistant Inspector General For Audits And Evaluations Office of Inspector General Department of Veterans Affairs Before The Committee On Veterans' Affairs United States House of Representatives Hearing On "Building VA's Future – Confronting Persistent Challenges in VA's Major Construction and Lease Programs" More

Congressional Testimony 10/30/2013
Statement of Richard J. Griffin Deputy Inspector General Office of Inspector General Department of Veterans Affairs Before the Committee On Oversight And Government Reform United States House of Representatives Hearing on VA Conferences in Orlando, Florida More

OIG CHALLENGE #5: INFORMATION MANAGEMENT

VA's Federal Information Security Management Act Audit for Fiscal Year 2013

5/29/2014 | 13-01391-72 | Summary |

Audit of VA's Pharmacy Reengineering Software Development Project

12/23/2013 | 12-04536-308 | Summary |