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 provide 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 all veterans. It is vital that VA's health care and benefits delivery work in tandem with support services like financial management, procurement, and information management to be valuable and useful to the veterans who turn to VA for the services and 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 and detect 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 the major management challenges and high-risk areas facing the Department within OIG's six strategic goals—health care delivery, benefits processing, financial management, procurement practices, information management, and workforce investment—with assessments of VA's progress on implementing OIG recommendations.

In addition to OIG's major management challenges, VA has provided a response to each sub-challenge outlined by OIG. OIG takes exception to VA's responses for sub-challenges 2B and 3B as they minimize the importance of OIG findings in these areas and in some instances are incorrect. OIG's position is supported by the reports that have been issued during the past year.

For sub-challenge 2B, Improving Data Integrity, Internal Controls, and Management Within VA Regional Offices' (VARO), OIG disagrees with VBA's statement that the claims-related documents found in employees' personal shred bins for non-claims-related documents at the Los Angeles VARO would have passed through the final internal control process of a Records Management Officer's (RMO) review. OIG found the Los Angeles VARO did not have an RMO at the time of our review, which is VBA's final control to prevent shredding of claims-related documents under its January 2011 policy on management of veterans' and other governmental paper records. Additionally, Support Service Division (SSD) staff who took over the duties of the RMO

at the Los Angeles VARO lacked training regarding maintaining, reviewing, protecting, and appropriately destroying veterans' and other governmental paper records.

In addition, VBA's assertion that only 0.0025 percent of the 438,000 documents reviewed by OIG at 10 VARO's during the national review of claims-related documents pending destruction at VAROs had the potential to affect benefits deflates the extent of inappropriate destruction of documents. Of the 155 claims-related documents, 69 (45 percent) were improperly scheduled for destruction; 2 of the documents affected benefits, 9 had the potential to affect benefits, and 58 did not affect benefits but were still required to be included in the veteran's claims folder or VBA's electronic system prior to destruction. OIG believes this error rate is a more accurate representation of the issue and is indicative of a systemic issue, and OIG reiterates that the potential effect on veterans cannot be minimized.

Finally, in their response VA states "VBA is addressing all recommendations made by OIG in the Follow-Up Audit of VBA's Internal Controls over Disability Benefits Questionnaires (DBQs)." This statement is incorrect. VBA did not concur with the report's Recommendation 5 and has reported they will not address this recommendation, which was that the Acting Under Secretary for Benefits revise VARO quality assurance review methodologies to review appropriate samples of claims including public-use DBQs.

For sub-challenge 3B, Improving Management of Appropriated Funds, the Interim Assistant Secretary for Management and Interim Chief Financial Officer's response concerning our report, Audit of VA's Conference Management for Fiscal Year 2014, states that OIG's assessment was based on an outdated VA policy on VA conference management and oversight, and did not identify any wasteful spending, abuse, or misuse of funds. Further, the response states that many of the issues of noncompliance identified by the OIG were the result of a complex and burdensome policy that did not accommodate how conferences were organized or executed across VA. Under the policy in place until March 2015, OIG identified a very high rate of noncompliance with VA's policy. While OIG agrees that VA implemented revisions to its policy on VA conference management and oversight in March 2015, OIG does not agree that the revisions invalidated the results of the review of conferences completed during FY 2014, nor improved overall accountability of the process. On the contrary, some of the "streamlining" in the policy, while likely to reduce VA organizations' compliance burden, weakened controls needed to ensure conferences are cost-effective and reduce the risk of inappropriate spending.

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

MICHAEL J. MISSAL
Inspector General

Major Management Priorities and Challenges

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OIG CHALLENGE #1: HEALTH CARE DELIVERY

-Strategic Overview-

Historically, the VHA has been a national leader in the quality of care provided to patients when compared with other major U.S. healthcare providers. However, in recent years, VHA has experienced significant challenges in delivering high-quality, timely healthcare in an environment of increased and varied demand, competing goals and priorities, operational inefficiencies, organizational barriers, and inadequate information systems to manage healthcare resources efficiently and effectively.

VHA continues to face its most significant challenges in ensuring timely access to high-quality healthcare, whether that care is provided within VHA or through VHA's ability to arrange for services in the community. During fiscal year (FY) 2016, the Office of Inspector General (OIG) published multiple hotline inspection reports documenting access to care concerns that have existed within VHA in recent years, to include non-compliance with VHA scheduling policies resulting in delays in patient care and delays in obtaining care in the community through the Veterans Choice Program and other VHA programs. In some instances, these conditions resulted in delays in healthcare, placing patients at unnecessary risk.

OIG's August 26, 2014 report, *Veterans Health Administration Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* identified numerous deficiencies in scheduling practices at the Phoenix VA Medical Center. Of particular concern, this year OIG published three reports identifying continuing access and quality of care challenges at the Phoenix VA Medical Center. In FY 2016, additional work by OIG identified continuing concerns regarding access to care issues in the urology service, a delay in care for a lung cancer patient, and access and quality of care deficiencies in the Emergency Department. Other conditions placing veterans at risk include weaknesses in testing and follow-up care of Veterans receiving prescription opioid pain medications; failure to plan for and maintain continuity of care during intermittent staffing shortages; lack of timely documentation in the medical record to ensure sound clinical decision-making; and deficiencies in Veterans Crisis Line Responsiveness and Quality.

OIG invests about 40 percent of its resources in overseeing the healthcare issues of our Nation's veterans by conducting inspections at VA medical centers (VAMCs) and community-based outpatient clinics (CBOCs), national reviews and audits, issue-specific Hotline reviews, and criminal investigations. The following subchallenges further highlight the major issues facing VHA today.

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

1. Promoting Safe Opioid Prescribing Practices

During FY 2016, the use of opioids to treat chronic pain and other conditions continued to be a serious concern in VA and the nation. While opioids are considered an important part of pain management, they are also associated with serious adverse effects. Patients prescribed opioids frequently have complex comorbid conditions, making them more likely to be given multiple medications that can interact dangerously with opioid medications and potentially lead to death. Clinicians vary widely in their chronic opioid therapy prescribing practices within VA and the Nation. An observed geographic variation cannot be accounted for even when taking

into account other factors such as the healthcare utilization of the population.[1] This suggests that there is little agreement regarding the appropriate use of opioids for treating pain, especially chronic noncancer pain.

In FY 2016, OIG's Office of Healthcare Inspections (OHI) published three Hotline inspection reports addressing various aspects of VA opioid prescribing practices. OIG's FY 2016 work on this topic identified many of the same issues previously reported in our FY 2014 national review, *Healthcare Inspection—VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy* (Report Number 14-00895-163, issued May 14, 2014).

In *Healthcare Inspection—Poor Follow-Up Care and Incomplete Assessment of Disability, VA San Diego Healthcare System San Diego, California* (Report Number 15-00827-68, issued January 5, 2016), OIG determined that the quality of care provided for a patient's chronic pain did not follow recommendations of the VA/Department of Defense (DoD) *Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain*, a clinical practice guideline developed to promote evidence-based management of patients' chronic pain. OIG found that system providers did not order urine drug testing, complete a suicide risk assessment, or obtain an opioid pain care agreement as part of the patient's chronic pain therapy. The patient continued to receive refills of an opioid without a face-to-face assessment with a provider for 22 months. Also, in *Healthcare Inspection—Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California* (Report Number 14-04897-221, issued March 30, 2016), OIG found that a primary care provider did not refer a patient who was on long-term high-dose opioid treatment to specialists for a second level review as required by VA policy.

In *Healthcare Inspection—Alleged Inappropriate Opioid Prescribing Practices, Rutherford County Community Based Outpatient Clinic, Rutherfordton, North Carolina* (Report Number 15-01982-113, issued September 29, 2016), OIG identified challenges with the clinical environment in which CBOC providers prescribe opioids and manage the pain-related needs of their patients. OIG noted a lack of non-opioid pain management options for outpatients and, despite the opening of the Veterans' Integrated Pain Management Clinic at the parent facility, the high demand for non-opioid pain management options continue. OIG also found that facility leadership and primary care providers needed to improve adherence to required benzodiazepine appropriateness evaluations for patients on chronic opioid therapy who have post-traumatic stress disorder. Further, OIG found that facility leadership needed to develop proactive organizational solutions to ensure that consistent monitoring and timely patient reassessments and prescription refills could occur.

[1] McDonald DC, Carlson K, Izreal D. Geographic Variation in Opioid Prescribing in the U.S. *J Pain.* 2012 Oct;13(10):988–96.

VA's Program Response
Estimated Resolution Timeframe: VA will continue to follow the trends of the Opioid Safety Initiative (OSI) key clinical metrics for Fiscal Year 2017
Responsible Agency Official: Under Secretary for Health
Associated Strategic Goal: Empower Veterans to Improve their well-being
Strategic Objective: Improve Veteran wellness and economy security
Associated Performance Measure(s): No public-facing measures are associated with this issue.

VA is actively engaged in a systemwide, multimodal approach to addressing opioid misuse and opioid use disorder in Veterans receiving care from VA. While these approaches are organized under several different and discreet programs, they are designed to be complementary and synergistic to achieve the same desired clinical outcomes; that is, safe and effective pain management. VA's own data, peer-reviewed medical literature, and the Centers for Medicare & Medicaid Services (CMS) suggest that VA is making progress relative to the rest of the Nation.

Fiscal year (FY) 2016 activities/milestones include: (1) utilizing VA's Academic Detailing (AD) program which includes dissemination of provider and patient education materials and promotion of VA evidence-based Clinical Practice Guidelines; (2) providing medication disposal services to allow Veterans to physically dispose of unwanted/unneeded medications; (3) standardized education "Taking Opioids Responsibly" including rationale for obtaining informed consent and routine urine drug screening for Veterans receiving opioids for longer than 90-days; (4) substance use disorder (SUD) treatment and on-going monitoring for Veterans who are diagnosed with SUD but who require opioid analgesics; (5) increased access to complementary and integrative medicine treatments for pain management; (6) providing opioid overdose education and naloxone distribution to high-risk patients; (7) regulation permitting VA prescribers to access the state Prescription Drug Monitoring Programs and VA to share their controlled substances prescribing data and drafted policy requiring VA providers to access state databases when prescribing controlled substance; (8) the opioid therapy risk report is available to VA prescribers at the point of care in the electronic medical record for a thorough assessment of risk for adverse outcomes facilitating more effective care coordination and case management; this complements the OSI dashboard aggregate trending data; and (9) publication of a study in the journal "*"PAIN"*[2].

VA Data
The OSI key clinical metrics measured from Quarter 4 FY 2012 (beginning in July 2012) to Quarter 3 FY 2016 (ending in June 2016) demonstrate VA's success with: 171,529 fewer patients receiving opioids (679,376 patients to 507,847 patients); 57,734 fewer patients

[2] Patterns of opioid use for chronic noncancer pain in the Veterans Health Administration from 2009 to 2011. Edlund MJ, Austen MA, Sullivan MD, Martin BC, Williams JS, Fortney JC, Hudson TJ. Pain. 2014 Nov;155(11):2337-43. doi: 10.1016/j.pain.2014.08.033. Epub 2014 Aug 29. PMID: 25180008.

receiving opioids and benzodiazepines together (122,633 patients to 64,899 patients); 90,588 more patients on opioids that have had a urine drug screen to help guide treatment decisions (160,601 patients to 251,189); 133,219 fewer patients on long-term opioid therapy (438,329 to 305,110); the overall dosage of opioids is decreasing in the VA system as 21,515 fewer patients (59,499 patients to 37,984 patients) are receiving greater than or equal to 100 Morphine Equivalent Daily Dosing. The desired results of the OSI have been achieved during a time that VA has seen an overall growth of 136,944 patients (3,959,852 patients to 4,095,350 patients) that have utilized VA outpatient pharmacy services. In reference to the site-specific report, *Healthcare Inspection—Poor Follow-Up Care and Incomplete Assessment of Disability, VA San Diego Healthcare System San Diego, California* (Report Number 15-00827-68, issued January 5, 2016), VA San Diego Healthcare System (VASDHS) has worked to improve opioid safety and to follow the universal opioid precautions detailed in the VA/DoD Clinical Practice Guidelines for Management of Opioid Therapy for Chronic Pain in a number of different ways. The OSI resulted in further attention to opioid safety beginning in July of 2013. An OSI team has presented education to various services on opioid safety topics. The educational efforts included alerting staff to required minimal opioid universal precautions which include yearly urine toxicology screens, signed opioid use agreement, yearly check of State Prescription Drug Monitoring programs and follow-up visits every 6 months. The OSI team reviews all patients receiving narcotics in doses greater than 100mg morphine equivalents and makes recommendations in the chart to help guide primary care providers with difficult cases.

Reports monitoring progress with elements of the Guidelines and the OSI were developed with the assistance of VISN 22 Pain Committee and VISN22 PBM team. Specific note were implemented to document State Prescription Drug Monitoring, and presence of completed opioid agreements. The VISN 22 PBM team established a dashboard that allows tracking of the metrics and allows drill down to the provider level. At this time, the dashboard includes all of the opioid precautions except monitoring follow-up visit frequency. In Q1-2 FY 2016, a report was developed to track face-to-face visit frequency, and this report is currently being validated. Academic Detailers from the VISN22 Academic Detailing program meet with providers who are outliers to provide education on pain management and universal opioid precautions.

Primary care providers also have access to the nationally developed Opioid Therapy Risk Report (OTRR) which provides clinical teams with real-time information at point of care about various factors that are related to patient safety when they are prescribing long-term opioid analgesics to Veterans suffering from pain. Specific data about patients who are prescribed long-term opioids include: patient opioid prescription history; opioid doses; urine toxicology; pain scores; mental health diagnoses; most recent visits with Primary Care, Pain and/or Mental health clinics; future or pending primary care visits; completion of the Chronic Opioid consent; and Overdose Education and Naloxone Distribution (OEND) Kit dispensing.

VHASDHS informatics established local clinical reminders which alert the provider at visits when an opioid agreement is required, a urine drug screen is required, and state prescription monitoring is required. These reminders are displayed to all providers. Additionally, an opioid refill note was developed that is utilized to document when a patient calls for an opioid renewal. The note lists the status of opioid universal precautions including the last face-to-face visit with the prescribing provider. Finally, a functional assessment template was developed for Primary Care to use to track changes in function over time to understand the impact of treatment.

In Summary, VHASDHS has made considerable progress in improving opioid safety. Monitoring follow-up visit frequency for patients on chronic opioid therapy is a recent addition to

our dashboard and reports. The OSI Team and Pain Council will continue to track progress monthly and report progress to VHASDHS Medical Executive Committee.

In reference to the site-specific report, *Healthcare Inspection—Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California* (Report Number 14-04897-221, issued March 30, 2016), the VA Long Beach Healthcare System (VALBHS) completed the following actions in FY 2016. In FY 2016, a Chronic Pain Management team was developed consisting of a Pain Specialist Physician, Pain Nurse Practitioner, Pain RN Case Manager, Pain Pharmacist, and Pain Psychologist. In Quarter 2, a Formal Chronic Pain Clinic Consult was established for tracking and monitoring patients beyond the Primary Care Chronic pain specialization. In Quarter 3, VALBHS developed an Interdisciplinary Chronic Pain Clinic emphasizing different methods of pain management. This clinic optimizes opioid dosage and focuses on patient safety. Also, this clinic optimizes pain modalities including holistic approaches to pain management.

VALBHS recognized that the combined efforts in supporting the OSI from various departments led to sequential and sustained progress towards the goals of the OSI. Additionally, VALBHS established a Patient Advisory Board. Members are the Chief of Primary Care, Chief of Mental Health/Provider, Chief Pharmacist, Pain Pharmacist, Chief of Pain, Inpatient Attending Physician, and Patient Advocate.

2. Care Continuity and Provider Coverage

To ensure continuity of care and minimize disruptions to patient care and follow-up, it is critical to develop and implement contingency plans for the sudden departure of care providers, staffing losses over time, and/or unexpected surges in demand. In FY 2016, OIG's OHI published two Hotline inspection reports detailing how the lack of staffing contingency plans contributed to significant patient care delays and patients being lost to follow-up. Effective staffing contingency plans would assist in not only identifying alternative care options, such as other VA facilities, non-VA care, or contracted care, but also in determining care priorities and methods for identifying high-risk patients.

In *Healthcare Inspection—Access to Urology Service, Phoenix VA Health Care System, Phoenix, AZ* (Report Number 14-00875-03, issued October 15, 2015), OIG determined that the Health Care System (HCS) suffered a significant urology staffing shortage, yet leaders did not have a plan to provide urological services during the shortage of providers in the Urology Service. HCS leaders' failure to respond promptly to the staffing crisis may have contributed to thousands of patients being "lost to follow-up" and staff frustration due to lack of direction.

In *Healthcare Inspection—Alleged Inappropriate Opioid Prescribing Practices, Rutherford County Community Based Outpatient Clinic, Rutherfordton, North Carolina* (Report Number 15-01982-113, issued September 29, 2016), OIG also noted how the CBOC experienced inadequate primary care provider staffing when a new provider abruptly resigned, leaving a panel of 1,100 patients without a provider. Patients were reportedly called about their clinic appointment cancellations during the first 2 days after the provider resigned; however, the facility had no contingency plan that would ensure continuity of, and access to, appropriate primary care. Reportedly, nurse practitioners assigned to the parent facility were detailed to see patients in the CBOC for a period of time, but this was not sufficient to cover the needs of patients on chronic opioid therapy. Nurse practitioners were unable to prescribe opioid medications, and the Chief of Primary Care had to fulfill this task by writing refill prescriptions from the facility 70 miles away.

VA's Program Response
Estimated Resolution Timeframe: 2020
Responsible Agency Official: Under Secretary for Health
Associated Strategic Goals:
Empower Veterans to Improve their Well Being
Manage and Improve VA Operations to Deliver Seamless and Integrated Support
Strategic Objective: Increase customer satisfaction through improvements in benefits and services delivery policies, procedures, and interfaces

Associated Performance Measure(s):

- OPM Federal Employees Viewpoint Survey Employee Engagement Index Score
- Employees have a feeling of personal empowerment with respect to work processes
- I feel encouraged to come up with new and better ways of doing things
- My organization's leaders maintain high standards of honesty and integrity
- Percent of patients who responded 'Always' regarding their ability to get an appointment for a routine checkup as soon as needed
- Percent of patients who responded 'Always' regarding their ability to get an appointment for needed care right away

Providing adequate staffing to meet the healthcare needs of patients is required in all healthcare systems. Planning for contingencies, including not only absences in critical staff due to illness or other personal circumstances but also situations in which these critical staff members leave abruptly, provides challenges for everyone. VA has taken multiple steps to try to address these challenges, including:

- Hiring primary care providers before patient case load increase to the level necessitating such hiring, using data such as a new provider's caseload already becoming 50 percent full. In addition, many practices have hired a "float" primary care provider to assist with unanticipated absences.
- Beginning to implement a policy expecting providers to give sufficient notice when they leave, with that expectation clearly spelled out when the provider is hired.
- Developing virtual care initiatives. One example is the joint Office of Rural Health (ORH) National Teleradiology Program (NTP), which provides remote, store, and forward image interpretation services to 20 rural VA sites of care where there are shortages in local radiology professionals. Since its 2010 inception, NTP has interpreted images for more than 350,000 rural Veterans at 20 rural sites across the country.
- Continuing to invest in new virtual care strategies, including TelePrimary Care, Telemental Health, TeleICU, and TeleAudiology.

- For rural populations, utilizing mobile medical units, telehealth technology, and close coordination with rural community providers. Transportation solutions include mobility management, shuttle service, and direct transport of rural Veterans to available VA providers.
- Deploying the Rural Expansion of Tele-Primary Care Enterprise-Wide Initiative. This initiative, Virtual IMPACT, is part of a comprehensive effort to provide timely access to primary care using telehealth clinical video technology. Virtual IMPACT uses a hub-and-spoke model of care to build a national solution that provides virtual primary care provider services to VHA sites with provider vacancies.
- Including the basic tenants of a contingency plan in the newly developed access policy and educating Group Practice Managers on the plan.
- Developing and implementing the Interim Staffing Program (ISP), which is VHA's ready-reserve of VACO-employed, VHA-credentialed, badged, and trained clinicians. ISP registered nurses support all aspects of nursing care, while its provider staff (including physicians, psychiatrists, psychologists, nurse-practitioners, and physician-assistants) deliver primary and subspecialty care. ISP clinicians arrive at subscribing VHA facilities ready to engage the electronic health record and to join the facility healthcare team in serving Veterans. Thus far in FY 2016, the scalable and expandable ISP has hired 39 additional clinicians to achieve a total clinician-complement of 120. Of our more-than125 deployments, several were critical and helped facilities preserve patient-access to care.
- Improving VHA's ability to recruit physicians through competitive salaries. The new annual pay ranges for primary care physicians approved by Secretary VA on June 22, 2016, will enhance VA's ability to recruit and retain highly qualified providers to serve our Nation's Veterans. This will take effect the first pay period following the required 60-day notification period in the Federal Register.

Ensuring optimal availability of staff for each specialty at all of VHA's 1,700 sites of care is a daunting challenge. Staffing to peak patient demand will dramatically increase costs, while staffing at average levels creates a waiting time for patients. No matter where the staffing level is at a given point in time, VHA will have unanticipated and sometimes unpredictable areas of provider loss leading to associated increases in waiting times. For example, losing nearly all of a urology department in a short time is a very different problem than losses associated with planned retirements. The strategic question is how to build reasonable contingency plans given many possible scenarios that may become reality. As noted above, these plans have included the use of telehealth, "float" hiring, and sharing of resources. In addition, many VA Medical Centers have chosen to implement contracts with local providers to support care being provided at facilities in as uninterrupted a manner as possible. Current authorities offer limited flexibility for offering overtime for employees or additional pay incentives for part time hires.

VHA's FY 2015 turnover rate was 9.3 percent. This includes voluntary quit rate of 4.9 percent and retirement rate of 3.2 percent and favorably compares to 18.8 percent quit rate and 30 percent total turnover rate among the healthcare and social services industry (Bureau of Labor Statistics, 2014). At the same time, sudden and unpredictable losses can lead to a local crisis. Certainly existing contracts, community care providers and locum tenens providers are an option.

To address long-term workforce shortages, ORH has partnered with the Office of Academic Affiliations since 2012 to invest in a Rural Health Training Initiative that provides workforce educational opportunities at 21 rural locations across the country for students, including

physicians, nurses, pharmacists, mental health workers, and other allied healthcare professionals. Offering training opportunities in rural settings is likely to attract new hires. To date, this continuing program has trained more than 1,100 students in rural settings.

See the VHA Response for Sub-Challenge #1A4, which addresses access to urology services at the PVAHCS.

Upon publication of the OIG report, Healthcare Inspection—Alleged Inappropriate Opioid Prescribing Practices, Rutherford County Community-Based Outpatient Clinic, Rutherfordton, North Carolina (Report Number 15-01982-113, issued September 29, 2016), OIG closed recommendations 1 through 6, which closed the report. The facility implemented a number of corrective actions to address the OIG recommendations. As part of the Opioid Safety Initiative, the facility implemented a new Primary Care Opioid Renewal note. The Opioid Safety Initiative staff worked with both Primary Care Serve and Mental Health Service to complete the evaluations for the opioid therapy patients receiving benzodiazepines. The Veterans Integrated Pain Management Clinic staff worked with System Redesign Coordinators to analyze processes and develop improvements to increase scheduling efficiency and timeliness. The Primary Care physician positions were fully staffed by the end of 2016, which resulted in a ratio of one Gap physician for every 10 primary care panels. Additionally, the Primary Care Service and Chief of the Mental Health Service educated the staff on the importance of provider to provider communication to coordinate care for posttraumatic stress disorder patients receiving both opioids and benzodiazepines. Lastly, each week during leadership morning report, each Community Based Outpatient Clinic (CBOC) reported on quality measures, workload, patient satisfaction scores, access, staff vacancies affecting productivity, and other quality oversight data in order to ensure regular communication between the facility leadership and CBOC leadership.

3. Ensuring Veterans Crisis Line Responsiveness and Quality

According to its Web site, "the Veterans Crisis Line connects veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline, online chat, or text."[3] In FY 2016, OIG's OHI published a Hotline inspection report, *Healthcare Inspection—Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York* (Report Number 14-03540-123, issued February 11, 2016), addressing allegations received from a complainant on May 8, 2014, as well as additional allegations received from the U.S. Office of Special Counsel on February 3, 2015, of unanswered phone calls or calls routed to a voicemail system, lack of immediate assistance to callers, untrained staff, and confusing contact information for the Veterans Crisis Line (VCL), located in Canandaigua, New York.

OIG found that some calls routed to back-up centers went into a voicemail system and that the VCL and back-up center staff did not always offer immediate assistance to callers. For example, OIG's review identified over 20 calls that were routed to voicemail at 1 backup center. When VCL management investigated these complaints, they discovered that backup center staff was not aware the voicemail system existed; thus, they did not return these calls. In addition to being uncertain as to how long callers were in backup center queues, VCL management reported that they were unsure if the back-up centers thoroughly reported every call through direct contact or disposition e-mails to the VCL staff. Although VCL management had not confirmed this concern using call number data, they reported that calls had gone to

[3] Veterans Crisis Line website, https://www.veteranscrisisline.net/, accessed 5/18/16.

back-up center voicemail systems without any notification to the VCL that a call had been received.

OIG also found that VCL social service assistants (SSAs), who do not answer calls but assist responders during interventions with individuals in crisis and conduct follow-up activities, did not receive orientation and ongoing training that met VCL training requirements. In addition, OIG could not find documentation that the majority of SSAs had received training on rescues and the use of potential resources. VCL supervisors could only find 2 of the 24 orientation checklists OIG requested for the SSAs hired between August 2012 and September 2014. During interviews, SSA staff reported that orientation consisted mostly of sitting with another SSA who may or may not have been experienced and access to a handbook that did not instruct them on specific SSA procedures or processes. Some SSAs stated that they did not feel they had adequate training and had received erroneous or inadequate information from other SSAs, including information regarding rescue procedures and consult resources.

OIG also identified gaps in the VCL quality assurance process, including an insufficient number of required staff supervision reviews, inconsistent tracking and resolution of VCL quality assurance issues, and a lack of collection and analysis of backup center data. OIG determined that a contributing factor for the lack of organized VCL quality assurance processes was the absence of a VHA directive or handbook to provide guidance for VCL quality assurance and other processes and procedures.

VA's Program Response
Estimated Resolution Timeframe: Fiscal Year (FY) 2016
Responsible Agency Official: Under Secretary for Health
Associated Strategic Goal: Empower Veterans to Improve their Well-being
Strategic Objective: Increase customer satisfaction through improvements in benefits and services delivery policies, procedures, and interfaces
Associated Performance Measure: Veterans experience of VA

Since its inception in July 2007, the Veterans Crisis Line (VCL) has answered nearly 2.4 million calls and initiated the dispatch of emergency services to callers in imminent crisis over 62,000 times. The Veterans Chat, an online, one-to-one "chat service" for Veterans who prefer reaching out for assistance using the internet, has answered nearly 294,000 requests for chat services since its inception on July 4, 2009. Since its inception in November of 2011, the Crisis Line texting service has answered nearly 56,000 requests for text services. The Text number is 838255. Staff has forwarded nearly 384,000 referrals to local VA Suicide Prevention Coordinators on behalf of Veterans to ensure continuity of care with Veterans local VA providers.

VCL has made significant progress in addressing the recommendations for quality assurance in response to OIG report, *Healthcare Inspection—Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York* (Report Number 14-03540-123, issued February 11, 2016). Canandaigua requested closure on recommendations 1, 5, and 6. Recommendations 2, 3, 4, and 7 remain in progress with a target completion of September 2016. Major milestones for FY 2016 include the following: realignment of VCL from Office of Mental Health Operations to VHA Member Services, resulting in increased call center resources and support; overall improvement of the New Employee Orientation experience, with

streamlined curriculum, instruction, tracking, and reporting for both Health Science Specialist Responders and Social Services Assistants; and silent call monitoring of Responder calls began April 2016, with 70 percent success rate with one or more monitors completed for 98 percent of responders. The Standard Operating Procedures have been modified and improved with feedback from front line staff, ongoing tracking and resolution of complaints and compliments, along with use of an End of Call Satisfaction Question; creation of a VCL Handbook, an internal guide for VCL Employees; and the contract with Link2Health Solutions was executed on April 1, 2016, including monthly reporting with Quality Assurance Metrics.

4. Ensuring Timely Information for Clinical Decision Making

Complete and accurate documentation in patient electronic health records (EHRs) is essential for sound, fully-informed clinical decision making. When VA patients receive care from non-VA providers, it is critical that non-VA assessment and treatment records are obtained and promptly scanned into VA EHRs. VA policy requires results from non-VA care to be scanned into EHRs; however, the policy does not include timeliness standards for doing so.[4] In FY 2016, OIG's OHI published two Hotline inspection reports that identified deficiencies in obtaining and scanning non-VA clinical records, and OIG continues to identify similar issues in our ongoing work.

In *Access to Urology Service at the Phoenix HCS (Report Number* 14-00875-03, issued October 15, 2015*)* and *Healthcare Inspection—Delay in Care of a Lung Cancer Patient, Phoenix VA Health Care System, Phoenix, Arizona* (Report Number 14-00875-325, issued September 30, 2016), OIG found that non-VA providers' clinical documents were not consistently available for HCS providers to timely review. Consequently, referring providers may not have addressed potentially important recommendations and follow-up because they did not have access to these non-VA clinical records. These records are vital in understanding a patient's overall health status and care. Gaps in non-VA documentation, such as those found in these two Hotline inspections, put patients at risk and make continuity of care between various providers and specialties more difficult to achieve.

VA's Program Response
Estimated Resolution Timeframe: Complete
Responsible Agency Official: Under Secretary for Health
Associated Strategic Goal: Manage and Improve VA Operations to Deliver Seamless and Integrated Support **Strategic Objective:** Enhance productivity and improve efficiency of the provision of Veteran benefits and services
Associated Performance Measure(s): No public-facing measures are associated with this issue

VHA guidance has been developed and implemented by Non VA Care Coordination (NVCC) staff. NVCC staff work with Community Care providers to retrieve all necessary medical documentation for inclusion into the Veteran's Electronic Health Record. Once this information has been received and included in the Veterans Electronic Health Record, it is available for VA clinicians. Community Care has published bulletin articles on the subject and presented information on the Monthly National Call performed by the Community Care Operations

[4] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

Program Office. The Monthly National Call provides a forum in which processes are reviewed, to include new processes, changed processes, or refresher information on current processes.

In FY 2016, in reference to access to urology services and the site-specific report, Healthcare Inspection - Access to Urology Service, Phoenix VA Health Care System (PVAHCS), Phoenix, AZ (Report Number 14-00875-03, issued September 30, 2016), the VA Long Beach Healthcare System (VALBHS) completed the actions described below. Prior to the report's release, PVAHCS increased its Urology staffing to 7.5 of its allocated 8.5 clinical staff. PVAHCS continues to recruit for one staff urologist. During 2016, PVAHCS reduced its average wait time to be seen in the Urology Clinic to 5 days for established patients and 14 days for new patients. Meetings between PVAHCS and TriWest leadership resulted in improved communications and more timely availability of records from non-VA healthcare providers. Tri-West coordinates care delivered by non-VA healthcare providers for the PVAHCS. All TriWest non-VA care providers are obligated by contract to provide medical records within 14 days. TriWest is obligated by contract to load those records into the portal within 48 hours of receipt so VA staff can retrieve the information. The results of services provided outside of the TriWest contract are returned to the Purchased Care Service and scanned into the computerized patient record system within four business days. PVAHCS and TriWest field staff conduct a weekly teleconference. PVAHCS reviewed eight cases identified by the OIG, took appropriate action, and addressed the results with the Veterans or their next of kin. On June 16, 2016, OIG closed report 14-00875-03 based on these actions.

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

1. Ensuring that VHA Scheduling Policies and Procedures are Followed So That Veterans Receive Timely Access to Care

In August 2014, OIG reported on a myriad of allegations regarding patient deaths, patient wait times, and scheduling practices at the Phoenix VA Health Care System. The report recommended, among other things, that the VA Secretary ensure that the facility follows VA consult guidance and appropriately reviews consults prior to closing them to ensure Veterans receive necessary medical care.

On June 20, 2016, OIG issued *Veterans Health Administration-Review of Alleged Manipulation of Appointment Cancellations at VA Medical Center, Houston, Texas* (Report Number 15-03073-275, issued June 20, 2016) addressing allegations that leadership at that facility and its associated CBOCs incorrectly recorded clinic cancellations as appointment cancellations requested by patients. OIG substantiated that two previous scheduling supervisors and a current director of two CBOCs instructed staff to incorrectly record cancellations as canceled by the patient. As a result, VHA's recorded wait times did not reflect the actual wait experienced by the Veterans and the wait time remained unreliable and understated. These issues have continued despite VHA having identified similar issues during a May and June 2014 systemwide review of access. These conditions persisted because of a lack of effective training and oversight. OIG made six recommendations to the Veterans Integrated Service Network (VISN) 16 Director to improve scheduling processes and ensure accountability for continued deficiencies.

OIG also published healthcare inspections which identified use of unapproved wait lists in calendar year 2015 at other facilities [*Eye Care Concerns Eastern Kansas Health Care System Topeka and Leavenworth, Kansas,* Report Number 15-00268-66*,* issued December 22, 2015; and *Access and Oversight Concerns for Home Health Services Washington DC VA Medical*

Center Washington, District of Columbia, Report Number 14-03823-19, issued November 16, 2015].

Since the allegations at the Phoenix VA Health Care System in April 2014, OIG has conducted extensive work related to allegations of wait time manipulation that were investigated by OIG criminal investigators. OIG continues to receive such allegations.

OIG needed to hold release of information regarding the findings of these investigations for a time when doing so would not impede any planned executive or administrative action. OIG has provided information to VA's Office of Accountability Review for appropriate action and has completed and published more than 70 of these administrative summaries of criminal investigations on wait times. To date there has been one successful criminal prosecution, but largely OIG has found instances of substantiated administrative misconduct were more appropriate for referral to the Department for any administrative personnel action deemed appropriate rather than criminal prosecution.

VA's Program Response
Estimated Resolution Timeframe: 2019
Responsible Agency Official: Under Secretary for Health
Associated Strategic Goal: Manage and Improve VA Operations to Deliver Seamless and Integrated Support
Strategic Objective: Enhance productivity and improve efficiency of the provision of Veteran benefits and services; Evolve VA information technology capabilities to meet emerging customer service/empowerment expectations of both VA customers and employees

Associated Performance Measures:

- Percent of patients who responded 'Always' regarding their ability to get an appointment for a routine checkup as soon as needed
- Percent of patients who responded 'Always' regarding their ability to get an appointment for needed care right away
- Percent of primary care patients who respond "Always" regarding their ability to get an appointment for a routine checkup as soon as needed
- Percent of specialty care patients who respond "Always" regarding their ability to get an appointment for routine checkup as soon as needed
- Percent of primary care patients who respond "Always" regarding their ability to get an appointment for needed care right away
- Percent of specialty care patients who respond "Always" regarding their ability to get an appointment for needed care right away

VHA has 30+ year old scheduling software is designed as multiple "clinics" (multiple schedule calendars) for each provider rather than single "resources" (or one schedule calendar) per

provider. The system does not allow VA the ability to measure or manage access with traditional community standards. For example, serving one patient by making multiple appointments at check-out requires over 10 minutes, hundreds of keystrokes, and review/management of multiple individual lists and clinics. This reality underlies the development, training, and implementation of a complex set of scheduling business rules among ~25,000 schedulers who turn over at a rate of ~25 percent per year in order to manage access in VA. In addition to the software, training, and turnover, the science of using certain administrative time stamps to reflect patient waiting times is underdeveloped.

In order to improve the reliability of the scheduling process, VA's strategic direction is multipronged: 1) move the evaluation and accountability for Veteran Access to measures that are more reflective of the Veterans experience of the scheduling process; 2) simplify the scheduling process, 3) improve the training, oversight and feedback and 4) improving electronic scheduling tools. VA has initiatives addressing each of these strategies in addition to improving customer service and Medical Support Assistant hiring. Even the most sophisticated scheduling software and processes does not address the fundamental question of how best to evaluate the adequacy of access to needed healthcare services. For instance, there are no healthcare industry-wide benchmarks for clinic waiting times. VHA has made the strategic decision to gauge the ultimate success of our Access initiatives through the eyes of the Veteran, using the Consumer Assessment of Health Providers and Systems (CAHPS) survey. Our current Agency Priority Goal (APG) for Access for FY 2016-2017 focuses on improvement in the percentage of Veterans who state they can *Always* or *Usually* receive Primary Care and Specialty Care services when needed for Routine Care (e.g. check-ups) and Care Needed Right Away (urgent care). This agency goal is based on a composite of 4 CAHPS items. We note that CAHPS represents the only access measure currently endorsed by the National Quality Forum. CAHPS has the additional advantages of 1) ability to benchmark with private sector health systems and 2) avoiding potential for manipulation by assessing self-reported ability to receive care when needed for routine and urgent medical problems.

While VA's updated scheduling policy has been published, the development and implementation of the electronic scheduling application known as VistA Scheduling Enhancement has very high leverage potential to improve the day to day processes. In addition, VA is working toward enabling patients to directly schedule their own appointments through a hand-held application.

Accomplishments this year in these areas include:

- Publication of the Declaration of Access establishing VHA's access direction.
- Publication of VHA Outpatient Scheduling Process and Procedures policy.
- Finalization and anticipated Publication in September 2016 of the Consult and Outpatient Clinic Practice Management Policy.
- Establishment of systematic oversight for Consult processes.
- Development and field testing of Version 1.0 of VistA Scheduling Enhancement (VSE) which converts VHA scheduling to a graphical point and click application.
- Development and field testing of Veterans Appointment Request app allowing Veterans to first request and eventually make their own appointments from handheld applications.
- MyVA Access best practice implementation and support in the area of access.
- VHA "stand downs" to address pending urgent consults and appointments
- Implementation of the Consult Trigger Tool, an oversight tool to help improve consult management

- Completion of the first Consult Improvement Initiative, consisting of a group of 6 facilities working together to improve their consult performance.
- Development of new management reports assisting facilities in right-sizing the number of practices needed to maintain access.

Future strategic goals include developing, implementing, and training improved VA electronic scheduling software; training existing and new staff on VA's new scheduling policy; and enhancing oversight and feedback.

In reference to the site-specific report, *Review of Alleged Manipulation of Appointment Cancellations at VA Medical Center, Houston, Texas* (Report Number 15-03073-275, issued June 20, 2016), VHA notes OIG's concern and it is being addressed locally. It does not appear that this is a systemic issue. VHA welcomes OIG's recommendations on policies and procedures across the enterprise.

In reference to the site-specific report, *Healthcare Inspection – Eye Care Concerns Eastern Kansas Health Care System Topeka and Leavenworth, Kansas, Report Number 15-00268-66*, the OIG substantiated that the Leavenworth VA Medical Center (VAMC) Eye Clinic staff used an unapproved wait list for patients awaiting cataract surgery. However, the OIG did not substantiate that the unapproved wait list was created to falsify cataract surgery wait times. The Eastern Kansas Health Care System (EKHCS) Director and the VISN 15 Heartland Network Director both agreed that the list not an unapproved wait list; rather it was an electronic checklist used to ensure Veterans received the appropriate and necessary pre-surgical work-up prior to cataract surgery. The checklist was a tracking mechanism that followed multiple facets of care, including progress of clinical work-up through clinical disposition, and was maintained at the local facility. No VHA-wide mechanism was available that met the specific needs of the eye clinic procedures. In his report, the Assistant Inspector General for Healthcare Inspections disagreed with their assessment and maintained that the review found that list was used to track patients awaiting cataract surgery in lieu of the electronic wait list. The OIG substantiated that providers did not consistently enter eye care requests for new Leavenworth VAMC and Topeka VAMC Eye Clinic patients using the consult referral process as required. However, they did not substantiate the allegation that the providers did not follow the required consult process in an attempt to falsify wait times. The OIG did not substantiate that cataract surgeries were completed unnecessarily for the two identified patients or that patients were harmed while awaiting surgery.

In reference to improving home health services and to address the site-specific report, *Access and Oversight Concerns for Home Health Services Washington DC VA Medical Center Washington, District of Columbia* (Report Number 14-03823-19, issued November 16, 2015), the DC VA Medical Center completed a number of actions to described below. In FY 2016, staff revised the Geriatric and Extended Care Organizational Chart outlining the restructuring of the program. The Director signed the revised policy, Medical Center Memorandum, No. 11D-33 H/HHA Program. Staff training for the policy has been loaded into Talent Management System. There is now improved communication of between GEC reviews and referral sources of H/HHA by adding them as a co-signer. There is improved monitoring and oversight of DC VAMC's H/HHA EWL to ensure Veterans and family members are informed of delay in services and appropriate steps are followed in accordance with policy. An H/HHA monitoring tool was developed to assess staffs compliance of the program quality indicators. Random quarterly audits will be conducted. Staff developed an enhanced GEC screening process to better track

and monitor referrals volume and dispositions. Additionally, there is ongoing monitoring and oversight activities of Veterans and community agencies receiving H/HHA services now occur.

2. Ensuring that VA Can Purchase Timely, High Quality Care in the Community

On February 11, 2016, OIG testified before the United States House of Representative's Subcommittee on Health, Committee on Veterans' Affairs, about the challenges VA faces in administering its purchased care programs. VA's purchased care programs include the Veterans Choice Program (VCP), Patient-Centered Community Care (PC3), Fee Basis Care, and other non-VA care programs. VA continues to experience challenges with Veterans receiving timely access to care in the VCP which was created in November 2014 under Public Law 113-146, Veterans Access, Choice, and Accountability Act of 2014.

On February 4, 2016, OIG issued *Review of Alleged Untimely Care at the Community Based Outpatient Clinic, Colorado Springs, Colorado* (Report Number 15-02472-46, issued February 4, 2016), substantiating the allegation that eligible Colorado Springs Veterans did not receive timely care in six reviewed services. The services were Audiology, Mental Health, Neurology, Optometry, Orthopedic, and Primary Care. OIG reviewed 150 referrals for specialty care consults and 300 primary care appointments and, of the 450 consults and appointments, 288 veterans encountered wait times in excess of 30 days. For all 288 veterans, VA staff either did not add them to the Veterans Choice List or did not add them to the list in a timely manner. Specifically, OIG found that:

- Scheduling staff used incorrect dates that made it appear the appointment wait time was less than 30 days for 59 of the 288 veterans; and
- Non-VA Care Coordination staff did not add 56 veterans to the VCL and did not add 173 veterans to the list in a timely manner; and
- Scheduling staff did not take timely action on 94 consults and primary care appointment requests.

As a result, VA staff did not fully use VCP funds authorized by Congress to afford Colorado Springs CBOC Veterans the opportunity to receive timely care.

Additionally, on February 5, 2016, OIG issued *Review of Alleged Patient Scheduling Issues at the VA Medical Center in Tampa, Florida* (Report Number 15-03026-101, issued February 5, 2016), substantiating that James A. Haley Veterans' Hospital staff did not always cancel the veteran's VA appointment when staff made a VCP appointment. Consequently, VA appointments were not available for other Veterans waiting for care. For example:

- OIG found that for 12 Veterans, staff did not cancel the Veterans' corresponding VA appointments because Non-VA Care Coordination staff did not receive prompt notification from the contractor when a Veteran scheduled a VCP appointment and no longer needed the VA appointment; and
- OIG substantiated that the facility did not add all eligible Veterans to the Veterans Choice List when their scheduled appointment was greater than 30 days from their preferred date, and that staff inappropriately removed veterans from the Veterans Choice List. This occurred because Tampa VAMC schedulers thought they were appropriately removing the veteran from the Electronic Wait List when they were actually removing the veteran from the Veterans Choice List.

VA's Program Response
Estimated Resolution Timeframe: Complete
Responsible Agency Official: Under Secretary for Health
Associated Strategic Goal: Manage and Improve VA Operations to Deliver Seamless and Integrated Support
Strategic Objective: Enhance productivity and improve efficiency of the provision of Veteran benefits and services
Associated Performance Measure(s): No public-facing measures are associated with this issue

VHA continues to work to improve access to care for all Veterans. Community Care has guidance outlining the process for managing Veteran Choice List appointments. This guidance has been reviewed in numerous training sessions, and is available for staff to download to be readily available. Information regarding this subject was also reviewed on a Monthly National Call.

In reference to the site-specific report, *Review of Alleged Untimely Care at the Community Based Outpatient Clinic, Colorado Springs, Colorado* (Report Number 15-02472-46, issued February 4, 2016), VHA has taken note of OIG's concern and shall address it locally. It does not appear that this is a systemic issue. VHA welcomes OIG's recommendations on policies and procedures across the enterprise.

VA Eastern Colorado Health Care System (ECHCS) fully supports the Veteran's right to pursue the "Choice" option if they meet eligibility criteria. We are currently in the top 5 facilities in the nation for the volume of referrals to the Veterans Choice Program. Through March of FY 2016, ECHCS has referred 27,716 episodes of care to our region's third party administrator, Health Net Federal Services (Health Net), resulting in 17,251 appointments in the community. To ensure we maintain this success, ECHCS has added Veterans Choice List entry criteria to the performance plans of schedulers and issued the revised plans during mid-year review in March 2016.

In regards to the appointment requests for newly enrolled Veterans within 1 day of the approved appointment, there is no known policy with this requirement. Per VHA Directive 2012-001 regarding time requirements for processing Enrollment applications, the office responsible for processing applications is responsible for processing all applications, regardless of the method of submission, into the Veterans Information Systems and Technology Architecture (VistA) within 5 business days of the time stamp date. The appointment requests for newly enrolled patients are populated onto the Newly Enrolled/Appointment Requested Report and processed daily by the site for which the Veteran requested care.

In reference to the site-specific report, *Review of Alleged Patient Scheduling Issues at the VA Medical Center in Tampa, Florida* (Report Number 15-03026-101, February 5, 2016), the Tampa VA Medical Center took the actions described below. The Acting Chief, Health Administration Service (HAS) collaborated with the VISN 8 Field Assistant who explained that any changes would require a national Contract Modification. At the national level, there are no plans for modification as the needed information is obtainable through the Health Net portal. HAS will continue to retrieve community CHOICE appointments through the portal and cancel VA appointments accordingly. On average, appointment notifications are received within two to ten days prior to the community CHOICE appointments.

The Acting Chief, HAS, validated that Health Net complies with the contract by updating the portal with the date/time of the community appointment. Health Net is not obligated to provide an electronic alert. HAS will continue to retrieve community appointments through the portal.

The HAS Performance Improvement (PI) section developed an audit program report in May 2015 which utilizes VistA. The report is run daily for the appointments made on the previous date. The report has three tabs that monitor Veteran's Choice List (VC List) entries, VCL Dispositioned entries, and appointments that should have been added to the VC List but were not. This report is sent daily via Outlook to all section chiefs and supervisors of scheduling staff with instructions on how to take action for each tab. The supervisors share the audit results with appropriate staff for awareness and corrective action.

HAS PI section runs the daily VC List reports to verify VC List entries were made. Those that have been dispositioned from the list are verified for "Deceased status" with Decedent Affairs staff. Veterans not identified as deceased are reported to supervisors to be re-entered correctly to the VC List. The HAS PI Committee performs ongoing audits for previously dispositioned Veterans, as well as audits to identify patients scheduled for appointments, but not entered to the VC List as required. The Committee reports their findings to the PI Section Chief. The PI Section Chief then sends a list to supervisors to have the corrective actions entered.

In accordance with the National Clarification to Scheduling Guidelines introduced in May 2015, the PI section conducted refresher scheduling training from July through September 2015. The training included CHOICE, Electronic Wait List/VC List training and was provided to all staff and supervisors possessing the scheduling menus. Staff were required to self-certify that they had attended, understood, and would comply with the training requirements. Training certification for those that attend training is entered in staff's Talent Management System (TMS) Learning History, and certification memorandums are maintained by the PI section.

The scheduling menus were removed from those staff that did not attend and certify compliance. CHOICE, Electronic Wait List /VCL training is now part of the scheduling training conducted at James A. Haley Veterans' Hospital prior to scheduling menus being assigned. Veterans are now entered on the VCL by a scheduler in the respective specialties.

OIG CHALLENGE #2: BENEFITS PROCESSING
-Strategic Overview-

Delivering timely and accurate benefits is central to VA's mission. The Veterans Benefits Administration (VBA) is responsible for oversight of the nationwide network of VA Regional Offices (VARO) 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 $104 billion in claims to Veterans and their beneficiaries in FY 2017.

OIG conducts inspections of all 56 VARO's and the Veterans Service Center (VSC) in Cheyenne, Wyoming, generally on a 3-year cycle to examine the accuracy of claims processing and the management of VSC operational activities. These inspections address the processing of high-risk claims such as temporary 100 percent disability evaluations, residual disabilities related to traumatic brain injuries (TBI), and special monthly compensation (SMC) claims and related ancillary benefits payments reserved for Veterans with quality-of-life issues due to

severe disabilities related to military service. In FY 2016, OIG inspected 5 VAROs—completing the second review cycle of VBA's 57 claims processing offices.

During FY 2016, OIG also reported the results of 14 reviews related to VBA programs, operations, and complaints received through OIG's Hotline Division. Since FY 2011, VBA has aggressively pursued multiple initiatives outlined in its Strategic Plan to eliminate the backlog of compensation claims, also referred to as rating-related claims. VBA's goal for reducing the backlog was to process all compensation claims within 125 days with 98 percent accuracy by 2015. However, OIG is concerned that the improvement made in reducing the backlog of compensation claims was at the expense of other VBA workload such as its non-rating and appealed claims workload.

The manner in which VBA reports and accounts for its workload lacks transparency and creates self-imposed challenges to managing that workload. For example, in April 2016, VBA reported it completed 135,172 dependency claims since the start of the FY—representing 32 percent of its target completion goal of 422,090 during FY 2016. As part of VBA's transformation efforts, VBA developed a Rules-Based Processing System (RBPS) to automate dependency claim submission and payment through self-service features; however, claims processed under RBPS are excluded from VBA's performance dashboards. VBA reported that over 60 percent of the dependency claims filed through RBPS are automatically processed and paid within 2 days; yet, dependency claims processed under traditional claims processing systems for FY 2016 have taken, on average, 353 days to complete. While VBA reports the success of RBPS, performance metrics such as the accuracy of claims processed using RBPS are unknown. It is unclear how VBA and stakeholders, to include OIG, can determine if VBA successfully reduced its inventory of dependency claims and whether or not improvement in this workload can be attributed to RBPS. Similarly, while VBA focused efforts on reducing its inventory of rating-related disability claims, its appealed claims inventory continued to rise. According to VBA's Monday Morning Workload Reporting system, the appealed claims inventory increased by 31 percent—from 247,780 in September 2011 to 325,291 as of May 14, 2016.

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

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 claims decisions. Claims processing that lacks compliance with VBA procedures could increase the risk of improper benefits payments to Veterans and their families. During inspections, OIG sampled claims with certain medical disabilities considered to be at higher risk of processing errors, thus results do not necessarily represent the overall accuracy of disability claims processing at the VAROs. In FY 2016, OIG reported on the performance of five VAROs in the following areas:

- Temporary 100 percent disability evaluations;
- Residual disabilities related to TBI;
- SMC and related ancillary benefits;
- Dates of claims; and
- Benefits reductions.

OIG determined VBA staff correctly processed disability claims related to TBI; however, 16 percent of the total 186 disability claims statistically selected from 5 VAROs that related to temporary 100 percent disability evaluations and SMC claims contained errors. The errors resulted in more than $186,000 in improper benefits payments. Specifically, VARO staff incorrectly processed:

- 20 percent of 114 temporary 100 percent disability evaluations, resulting in identification of more than $138,100 in improper benefits payments; and
- 32 percent of 19 claims involving SMC and ancillary benefits, resulting in identification of more than $47,900 in improper benefits payments.

VARO staff used incorrect dates when establishing claims in VBA's electronic system of records for 1 percent of the 150 cases reviewed. OIG also determined VARO staff did not correctly process or complete 26 percent of 141 proposed benefits reductions cases, resulting in approximately $206,400 in improper benefits payments. For the cases with processing delays, an average of 6 months elapsed before staff took the required actions to reduce benefits.

In FY 2014, as part of its transformation initiatives, VBA implemented an issue-level model for reporting the accuracy of claims processed at VAROs—deviating from its traditional claim-level model for reporting accuracy. VBA explained that under the issue-level model, a claims processor that properly decided 15 out of 16 medical issues correctly received an accuracy rate of 93.7 percent. Under the claim-level model, if one of the 16 issues were incorrectly decided, the entire claim would be an error. VBA began concurrently tracking the accuracy of rating-related disability claims using the traditional and claim-level model. Under the claim-level model, the accuracy of rating-related claims remained at approximately 90 percent while the accuracy of claims using the issue-level model remained around 96 percent through the second quarter of FY 2016. As such, OIG is concerned that the increased accuracy reported using the issue-level model is related to the change in methodology rather than actual improvement in the accuracy of claims being processed**.**

Additionally, in March 2015, VBA implemented a regulatory change that standardized the manner in which beneficiaries must submit claims. Prior to the regulatory change, beneficiaries were entitled to submit a claim in any format, including handwritten notes or letters. The regulatory change included a new "intent to file" process. VBA reported that the formalized process gives applicants additional time to gather all of the information and evidence needed to submit their formal application for benefits; however, VBA has a fundamental duty to assist

Veterans in this process. OIG is concerned that the new policy created a mechanism in which claims processing staff could reject claims unless it was submitted on a specific form, thereby delaying assisting Veterans with their claims and ultimately in the delivery of benefits and services.

VA Program Response
Estimated Resolution Timeframe: 2017
Responsible Agency Official: Under Secretary for Benefits
Associated Strategic Goal: Empower Veterans to Improve Their Well-being
Strategic Objective: Increase customer satisfaction through improvements in benefits and services delivery policies, procedures, and interfaces

Associated Performance Measures:

- Percentage of VA Disability Rating Claims pending more than 125-days
- Percentage of Disability Compensation Rating Claims inventory pending more than 125-days
- National Accuracy Rate – Disability Compensation Rating Claims
- National Accuracy Rate – Disability Compensation Rating Claims – Issue Based
- Percent of Disability Compensation Claims received virtually/electronically
- Percentage of Dependency and Indemnity Compensation Claims inventory pending more than 125-days
- Non-Rating Claims, Compensation Average Days Pending
- Non-Rating Claims, Compensation Average Days to Complete
- Dependency Claims Processing: Inventory (Claims Pending)
- Dependency Claims Processing: Timeliness (Month-to-Date Average Days to Complete as of the last month of the year)
- Compensation: Overall customer satisfaction index score (out of 1000)
- Appeals Processing - Notices of Disagreement (NODs) Average Days Pending
- Appeals Processing - Formal Appeals to the Board (Form 9) Pending Inventory
- Appeals Processing - Notices of Disagreement (NODs) Pending Inventory

The Veterans Benefits Administration (VBA) is committed to providing Veterans with the care and services they have earned and deserve. As of September 30, 2016, the average age of pending compensation claims was 85 days, a 197-day reduction from the 282-day peak

in March 2013. For the seventh year in a row, VBA completed over a million disability claims. Even as VBA focused on its priority goal to eliminate the disability rating claims backlog for Veterans who have waited the longest, and is achieving record-breaking levels of production, VBA remained focused on non-rating claims, as well. As VBA completed record-breaking numbers of disability rating claims in recent years, one result is an associated increase in the volume of non-rating claims and appeals. Despite completing three million non-rating and administrative action end products in fiscal year (FY) 2016, this volume of work continues to grow.

VBA developed the Rules-Based Processing System (RBPS) to automate adjustments for adding or removing dependents. During FY 2016, 66 percent of the dependency claims submitted through RBPS were automatically processed and Veterans' award adjustments were completed within one day. Claims that do not fit the criteria for automatic processing or claims that cannot be validated through the automated rules-based decision criteria are routed for manual processing. VBA will continue to focus efforts on completing the oldest dependency claims while continuing to reduce overall inventory. In the third quarter of FY 2016, VBA continued to track improvement projects across identified work streams to increase the volume of dependency claims eligible for automatic processing. Distribution of dependency claims through the National Work Queue (NWQ) will increase, further adding claims processing efficiency. VBA will continue to work with the myVA initiative to prioritize information technology improvements and market the electronic submission channels that enable automatic dependency claim processing.

Modernizing the appeals process through legislative reform and other people, process, and technology initiatives is one of VA's 12 Breakthrough Priorities. VBA received funding that allowed the hiring of 200 additional appeals full-time employees in FY 2016, increasing the appeals workforce to 1,495 employees. VBA also allocated $10 million in overtime funds for the appeals workload. The additional funding has allowed VBA to increase its appeals output to more than 202,000 appeals actions in FY 2016, which represents a 20 percent increase over FY 2015. VBA was able to lower the Substantive Appeal (VA Form 9) pending inventory by 11 percent, and the Board remand inventory by 8 percent in FY 2016, while maintaining a steady NOD pending inventory, compared to FY 2015. In addition, VBA issued over 30,000 more statements of the case in FY 2016 compared to the previous year. Overall, VBA resolved 113,197 appeals in FY 2016 – over 15,000 more appeal resolutions compared to FY 2015. Furthermore, beginning in November 2015, VBA started gathering requirements for processing appeals in VBMS, leveraging efficiencies through automation and the NWQ. However, as VA has increased claims decision output over the past 6 years, appeals volume has grown proportionately.

Despite the people, process, and technology improvements, increases in productivity have not been significant enough to keep pace with inflow of new appeals and the current appeals workload is projected to continue to grow. VBA received more than 176,000 new appeals in FY 2016 – nearly 63,000 appeals more than it was able to resolve. Within the current legal framework, the average processing time for all appeals resolved in FY 2016 was approximately 3 years. For those appeals that reach the Board, on average, Veterans were waiting at least 5 years for an appeals decision, with thousands of Veterans waiting much longer. VA projects that under the current process, without significant legislative reform, Veterans will be waiting an average of 10 years for a decision on their appeal by the end of 2027. Comprehensive legislative reform is required to modernize the VA appeals process and provide Veterans a decision on their appeal that is timely, simple, transparent, and fair. In early 2016, VA sponsored an "Appeals Summit" – a series of meetings held with Veterans Service

Organizations (VSOs), advocacy groups, and congressional staff to design a new appeal process, with additional meetings and ongoing communication following. The product of these collaborative, detailed discussions between VA, VSOs, and other key stakeholders was a new appeals framework. VA provided Congress with draft language setting forth this framework, which is the subject of four bills pending in Congress (H.R. 5083, H.R. 5620, S. 3170, and S. 3328).

Nationally, claim-based accuracy increased from 84 percent in FY 2011 to 88.1 percent (+/- .8 percent margin of error), as of September 30, 2016, and issue-based accuracy remained high at 95.5 percent (+/- .3 percent margin of error). Issue-based accuracy is measured by assessing each medical disability decision within a rating-related compensation claim. Each issue a Veteran raises must go through the same series of discrete tasks, such as VBA providing duty to assist, gathering evidence, and making the decision. VBA may err on one aspect of the claim for a medical issue, but correctly process the remaining issues within the claim. Hence, the outcome of claim-based accuracy, which considers a claim to be processed either correctly or incorrectly, is not beneficial for analysis or training purposes and presents a misleading picture of VBA's accuracy. Issue-based accuracy provides VBA the opportunity to precisely target medical issues where adjudication is more error-prone and additional training is needed.

VBA continues to gain efficiency as a result of a blend of people, process, and technology improvements. The automation capabilities provided by the Veterans Benefits Management System (VBMS), coupled with the implementation of the NWQ and the Centralized Mail (CM) program, are clear examples of enhancements to increase the efficiency of claims processing.

VBMS deployed major releases in FY 2016, using an agile development model to deliver new functionality and enhancements to users every three months. These releases focused on the reduction of legacy systems, as well as automation, integration with the Department of Defense (DoD), and electronic access to communications for Veterans. For enhanced efficiency, VBMS can now systematically request DoD service treatment records when a Veteran initiates his or her claim. Additionally, VBMS now automatically triggers a review of a claim when requested evidence is marked as received, helping move the claim toward a decision.

In February 2016, VBA launched NWQ, a national workload distribution tool. NWQ was built within VBMS and takes advantage of paperless capabilities to improve VBA's overall production capacity and assist with reaching claims processing goals. With 99.7 percent of the pending disability compensation claims inventory converted to a digital format, VBA is able to efficiently and centrally manage the claims workload, set priorities nationally, and electronically distribute claims that are ready to be worked based on individual regional office (RO) capacity levels. As of May 8, 2016, all ROs are receiving disability rating claims through NWQ.

VBA completed deploying CM to all ROs in 2015, and completed deploying CM to the Pension Management Centers in FY 2016. Since deployment, VBA has gained proficiency in electronic mail processing and is now able to provide assistance with virtual mail processing as needed across ROs. VBA continues to explore the possibility of expanding CM use to other business lines.

Prior to March 24, 2015, Veterans could submit claims in any format, including handwritten notes or letters. This practice sometimes led to VBA discovering claims later in the process. Effective March 24, 2015, VBA regulations made the claims process easier and more efficient for Veterans through the use of standardized claim and appeal forms. This regulatory change includes a new intent to file (ITF) process that replaces informal claims. The ITF process gives

applicants additional time to gather all of the information and evidence needed to submit with their formal application for benefits. The ITF process protects the earliest possible effective date if VBA determines that the applicant is eligible for benefits and helps ensure anyone wishing to file a claim receives the information and assistance he or she needs.

VBA also developed and mandated new refresher training course for Veterans Service Representatives, Rating Veterans Service Representatives, and Decision Review Officers regarding special monthly compensation (SMC). In addition, VBA updated training materials on the following topics for the Veterans Service Center personnel:

- Temporary 100-percent disability evaluations
- Traumatic brain injury
- SMC and related ancillary benefits
- Dates of claims
- Benefits reductions

OIG Sub-Challenge #2B: Improving Data Integrity, Internal Controls, and Management Within VAROs (VBA)

VBA continues to experience challenges in ensuring all 56 VAROs comply with the Veterans Health Information Systems and Technology Architecture (VistA) regulations and policies and deliver consistent operational performance. During FY 2016, OIG published 14 reports relating to VBA program operations, management, and allegations of wrongdoing. In total, OIG made 41 recommendations for improvement and substantiated many of the allegations raised through OIG's Hotline. Recommendations for improvement addressed data integrity issues, weaknesses in internal controls, and mismanagement of VBA operations and programs. Specific challenges that OIG reported on in FY 2016 are summarized in this section.

In May 2016, OIG identified concerns warranting VBA management attention while assessing the merits of allegations that VARO management inappropriately interfered with established procedures for reconsidering local quality review errors at the San Diego VARO. In *Review of Alleged Manipulation of Quality Review Results at VA Regional Office San Diego, California*, (Report Number 15-02376-239, issued May 9, 2016), OIG determined VBA's local quality review program lacked controls sufficient to ensure staff took timely actions to correct claims processing errors identified during the quality review process. Of the 50 errors OIG sampled, 39 required corrective actions, such as revised decision documents, while the 11 remaining errors related to actions like improper development for evidence which did not require revised decision documents. On average, it took VARO staff 66 days to correct the errors. OIG recommended the San Diego VARO Director implement a plan to ensure staff comply with local policy to correct individual quality review errors and that the Under Secretary for Benefits (USB) establish a timeliness standard for VBA staff at its 56 VAROs to follow when correcting individual quality review errors.

OIG issued two reports, *Review of Alleged Data Manipulation of Appealed Claims at VA Regional Office Wichita, Kansas* (Report Number 15-03581-204, issued April 26, 2016) and *Review of VBA's Alleged Inappropriate Prioritization of Appeals at VA Regional Office Roanoke, Virginia* (Report Number 15-02384-212, issued April 19, 2016), related to data integrity and mismanagement. The data integrity issues regarding appealed claims processing actions at the Wichita VARO resulted from a lack of management oversight and conflicting guidance provided by the Compensation Service. The guidance required VARO staff to enter incomplete and/or inaccurate information in Veterans Appeals Control and Locator System (VACOLS). VACOLS

is the electronic records system used to track and manage its appeals workloads—the effectiveness of tracking appealed claims is dependent upon the accuracy and timeliness of the information entered. OIG reviewed 36 Notices of Disagreements (NOD) at the Wichita VARO and found staff did not follow VBA policy when processing this workload. In addition to recommending that VARO staff correct the errors OIG identified, the USB modified the policy on processing the appealed claims workload to ensure appellate claims are accurately processed.

At the Roanoke VARO, OIG confirmed that leadership did not follow workload management plans, which required appeals staff to prioritize appealed claims based on the age of the appealed claims. Instead, as directed by VBA's Southern Area Office Director to reduce appeals inventory, Roanoke VARO management implemented a NOD reduction plan. The reduction plan focused on processing less complex, newly initiated appeals. OIG confirmed that 82 percent of the appealed claims processed by Roanoke VARO staff in FY 2014 had been pending less than 1 year and that older appealed claims were not processed.

In January 2015, OIG received an anonymous allegation that staff at the Los Angeles, California, VARO were shredding mail related to veterans' disability compensation claims. The complainant also alleged that supervisors were instructing staff to shred these documents. OIG substantiated in *Review of Alleged Shredding of Claims-Related Evidence at VA Regional Office Los Angeles, California* (Report Number 15-04652-266, issued April 14, 2016), that VARO staff were not following VBA's January 2011 policy on management of Veterans' and other governmental paper records. OIG found nine claims-related documents that VARO staff incorrectly placed in personal shred bins for non-claims-related documents—eight of which had the potential to affect Veterans' benefits. OIG could not determine if records were incorrectly shredded prior to the visit because, as part of the normal contractor shred schedule, documents stored for destruction were picked up 11 days prior to OIG's visit. OIG will continue to follow up on the VARO's progress toward implementing the recommendations and corrective actions made in the report.

In order to determine whether the improper destruction of Veterans' claims-related documents was an isolated problem or a systemic issue, OIG conducted unannounced inspections at 10 selected VAROs across the nation. The 10 sites were Atlanta, Georgia; Baltimore, Maryland; Chicago, Illinois; Houston, Texas; New Orleans, Louisiana; Oakland, California; Philadelphia, Pennsylvania; Reno, Nevada; San Juan, Puerto Rico; and St. Petersburg, Florida. OIG found that VBA's controls were not effective to prevent VARO staff from potentially destroying claims-related documents, identifying 69 of 155 claims-related documents improperly scheduled for destruction at 6 of the 10 VAROs. As such, OIG concluded this was a systemic issue within VBA. OIG found that noncompliance with policy, inadequate controls, and outdated guidance led to the potential destruction of claims-related documents. VARO management and staff found VBA's policy confusing, they did not always receive annual training as required, and records management staff did not consistently review documents or maintain violation logs. These actions put documents at risk for inappropriate destruction, which can result in loss of claims and medical evidence, incorrect decisions, and delays in claims processing.

Additionally, VBA's shredding policy contained control weaknesses because supervisors were not required to document or track shredding violations, and records management staff were only required to spot check documents identified by employees as non-claims-related. The policy also lacked standardized procedures for the collection of documents, and VBA had not updated its policy to include procedures for electronic claims processing. OIG made seven recommendations in the report *Review of Claims-Related Documents Pending Destruction at VA Regional Offices* (Report Number 15-04652-146, issued April 14, 2016) to the Acting USB,

including revising VBA policy on management of veterans' and other Governmental paper records to ensure documents printed from Veterans Benefits Management System (VBMS) are clearly identified, and to provide detailed standardized procedures for the collection and review of material by records management staff.

Furthermore, OIG confirmed that St. Petersburg VARO staff did not adequately prepare documents for scanning at VA contracted scanning facilities. OIG observed claims evidence that was improperly stored, comingled with contractor documentation, or that was disorganized and not ready for scanning. Overall, the St. Petersburg VARO had more than 41,900 mail packages containing claims material and over 1,600 boxes requiring scanning. OIG also found that VBA did not provide effective oversight of contractor personnel to ensure documents were timely processed or safeguarded at the contractor facility.

On February 25, 2016, OIG published the results of an audit to assess VBA's implementation of its 2012 recommendations to strengthen internal controls over Disability Benefit Questionnaires (DBQs) and to determine whether VBA could use DBQs more effectively. In Follow-Up Audit of VBA's Internal Controls Over Disability Benefits Questionnaires (Report Number 14-02384-45, issued February 25, 2016), OIG found VBA did not establish adequate controls to identify and minimize potential DBQ fraud or fully implement OIG's prior recommendations to address control weaknesses. OIG estimated that claims processors did not identify approximately 23,100 of about 24,700 claims (93 percent) that included DBQs. Generally, this occurred because VARO staff did not consistently and correctly apply special issue indicators in VBA's electronic systems to identify claims that included DBQs, and VBA lacked adequate policies and procedures and quality assurance reviews. Further, unnecessary medical examinations caused Veterans and VA to needlessly expend time and money and may have delayed Veterans receiving benefits. OIG estimated VA will spend at least $4.8 million annually and at least $24 million over the next 5 years for unnecessary VA examinations if DBQs are not used more effectively.

VA Program Response
Estimated Resolution Timeframe: 2017
Responsible Agency Official: Under Secretary for Benefits
Associated Strategic Goal: Empower Veterans to Improve Their Well-being
Strategic Objective: Increase customer satisfaction through improvements in benefits and services delivery policies, procedures, and interfaces

Associated Performance Measures:

- Percentage of VA Disability Rating Claims pending more than 125-days
- Percentage of Disability Compensation Rating Claims inventory pending more than 125-days
- National Accuracy Rate – Disability Compensation Rating Claims
- National Accuracy Rate – Disability Compensation Rating Claims – Issue Based
- Percent of Disability Compensation Claims received virtually/electronically
- Percentage of Dependency and Indemnity Compensation Claims inventory pending more than 125-days
- Non-Rating Claims, Compensation Average Days Pending
- Non-Rating Claims, Compensation Average Days to Complete
- Dependency Claims Processing: Inventory (Claims Pending)
- Dependency Claims Processing: Timeliness (Month-to-Date Average Days to Complete as of the last month of the year)
- Compensation: Overall customer satisfaction index score (out of 1000)

VBA takes seriously the issues OIG raised and has taken action to address them, and will continue to do so until they are resolved.

The issue related to appeals workload management was specific to the Roanoke RO, which VBA addressed locally rather than systemically. Five of the OIG reports noted above resulted in national recommendations, and VBA is implementing them as expeditiously as possible. On March 4, 2016, VBA established a five-day standard for correcting errors identified by Quality Review Teams. VBA reminded all RO staff about the policy for controlling appeals on April 28, 2016. In March 2015, as a result of OIG's findings from the St. Petersburg RO, VBA increased the number of visits to the scanning facilities, provided more detailed instructions for site audits, and authorized an on-site government staff member for each mail intake site.

VBA is committed to ensuring Veterans' records are protected and maintained with accuracy and care. OIG inspected the Los Angeles RO in January 2015, to review documents pending destruction. OIG reviewed approximately 13,800 documents to be shredded and found 9 claims-related documents in individual employees' shred boxes/envelopes, demonstrating a 99.93 percent accuracy rate of the RO's shredding process. VBA believes that OIG intercepted all of these documents before they completely passed through the RO's internal controls process, including the Records Management Officer's review. The OIG proceeded to conduct additional inspections regarding documents pending destruction at 10 ROs, reviewing 438,000 documents and noting 11 documents (0.0025 percent) that were erroneously identified for

disposal and had the potential to affect benefits. While VBA knows that every Veteran's record is important and sincerely regrets these errors, it has been working diligently to eliminate the potential for errors by transforming its antiquated paper-based system to a fully electronic environment. Conversion of paper records to digital records significantly strengthens the systemic protection of Veterans' claim documents, early and rapidly integrating them into the Veterans' electronic claims folders. Ensuring these protections remains a top priority for VBA. VBA is also in the process of revising its records management policy to align with the current environment, which provides electronic document storage and centralized mail handling.

VBA is addressing all recommendations made by OIG in the *Follow-Up Audit of VBA's Internal Controls over Disability Benefits Questionnaires (DBQs)*. VBA revised the Adjudication Procedures Manual, M21-1, to clarify procedures pertaining to public-use DBQs. Specifically, the revisions updated guidance on how to obtain missing information from public-use DBQs, procedures for determining if clinicians who prepared the public-use DBQs are private or Veterans Health Administration clinicians, and additional steps to take after receiving insufficient public-use DBQs.

VBA also made improvements to the local quality assurance reviews. On January 1, 2016, VBA released a revised in-process review checklist to address compliance with public-use DBQ indicators, RO compliance with complete clinician's information on the public-use DBQs, and whether claims processors obtained unnecessary examinations after receiving DBQs adequate for rating purposes. In addition, on May 15, 2016, a revised Systematic Technical Accuracy Review checklist captured whether the submitted public-use DBQ was adequate for rating purposes.

VBA revised the standard operating procedure (SOP) for reviewing DBQs completed by non-VA providers. The revised SOP requires Compensation Service (CS) to analyze local quality assurance reviews to identify systemic issues related to the use of special-issue indicators, complete clinician information, and potential instances of unnecessary examinations.

VBA continues to assess the business requirements to verify the credentials of private physicians. VBA is also in the process of implementing front-end controls in the Veteran Claims Intake Program and Centralized Mail Portal, verifying the examiner by the National Provider Identifier (NPI), and by adding the private provider NPI as a data field so data can be pulled and sorted through data requests.

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. OIG's oversight assists VA in identifying opportunities to improve the quality of VA's financial information, systems, and assets. Addressing these and other issues related to financial systems, information, and asset management would promote improved stewardship of the public resources entrusted for VA's use.

For the 17th consecutive year, OIG's independent auditors provided an unqualified opinion on VA's FY 2015 and FY 2014 consolidated financial statements (CFS). With respect to internal controls, the contractor identified four material weaknesses, Information Technology Security Controls (a repeat condition); Procurement, Undelivered Orders, and Reconciliations; Purchase

Care Processing and Reconciliations; and Financial Reporting. The independent auditors also identified two significant deficiencies, Accrued Operating Expenses (a repeat condition) and CFO Organizational Structure for VHA and VA. Additionally, the contractor reported that VA did not substantially comply with Federal financial management systems requirements and the United States Standard General Ledger at the transaction level under P.L. 104-208, Federal Financial Manager Improvement Act (FFMIA) of 1996, and cited instances of non-compliance with section 5315 of title 38 of the United States Code pertaining to the charging of interest and recovery of administrative costs. The independent auditors will follow up on these internal control and compliance findings and evaluate the adequacy of corrective actions taken during the FY 2016 audit of VA's CFS.

OIG Sub-Challenge #3A: Compliance with the Improper Payments Elimination and Recovery Act (Office of Management (OM), VHA, VBA)

OIG conducted an FY 2015 review to determine whether VA complied with the requirements of P.L. 111-204, Improper Payments Elimination and Recovery Act (IPERA) of 2010. VA reported improper payment estimates totaling approximately $5 billion in its FY 2015 Agency Financial Report (AFR), compared with $1.6 billion for FY 2014, primarily because of improvements in estimating improper payments for four programs. In both years, VA reported improper payment data based on the previous fiscal year activity. VA did not fully comply with IPERA. In fact, the Office of Management and Budget (OMB) designated the VA Community Care, Purchases Long Term Services and Support programs, and the Compensation programs as high-priority programs in FY 2016. Each of these programs had estimated improper payments in excess of OMB's threshold of $750 million. This designation places additional requirements on VA and OIG for FY 2016 reporting.

VA met four of six IPERA requirements for FY 2015 by publishing the AFR, performing risk assessments, publishing improper payment estimates, and providing information on corrective action plans. VA did not comply with two of the six IPERA requirements by not maintaining a gross improper payment rate of less than 10 percent and not meeting reduction targets for all programs published in the AFR. The two programs that exceeded the 10 percent threshold are the VA Community Care program and Purchased Long Term Care Support and Services program. The programs that did not meet reduction targets are: (1) Compensation; (2) Education Chapter 1606; (3) Education Chapter 1607; (4) VA Community Care; (5) Purchased Long Term Services and Support; (6) Beneficiary Travel; (7) Supplies and Materials; and (8) Disaster Relief Act—Hurricane Sandy.

In addition, VHA underestimated improper payments for one program and did not achieve the expected level of accuracy for two others. Likewise, VBA expended considerable effort to collect improper payments because of a program design issue with drill pay, and it needs to develop a plan and seek the assistance of Office of Management and Budget to coordinate future resolution. VA management concurred with OIG's recommendations, and OIG will follow up on corrective actions in the FY 2016 review.

OIG also conducted an audit to evaluate VBA's oversight of the Post-9/11 Veterans Educational Assistance Act of 2008 (Post-9/11 G.I. Bill) tuition and fee payments to determine if payments were appropriate and accurate (Report Number 14-05118-147, issued September 30, 2016). OIG's review of a sample of more than $1.7 million in payments made during the academic year from August 1, 2013, to July 31, 2014, determined that VBA Regional Processing Offices (RPOs) had made 46 improper payments to 20 schools. The RPOs made these improper

payments totaling just under $90,900 on behalf of 43 of the 225 students reviewed. These improper payments occurred because:

- School certifying officials made errors, were unaware of program requirements, or did not follow program requirements when they submitted students' certifications for payment;
- VBA did not ensure sufficient verification and monitoring of tuition and fee certifications;
- VBA lacked adequate guidance on allowable book fees and repeated classes; and
- VBA did not verify and obtain supporting documentation for mitigating circumstances.

Of the more than $5.2 billion in payments made in academic year 2013-2014, OIG projected that VBA made about $247.6 million in improper payments. If VBA does not improve program controls, improper payments could total an estimated $1.2 billion over the next 5 academic years.

OIG also identified improper payments concerning incarcerated Veterans in *Audit of VBA's Compensation and Pension Benefit Payments to Incarcerated Veterans* (Report Number 13-02255-276, issued June 28, 2016). OIG conducted an audit to determine whether VBA was adjusting compensation and pension (C&P) benefit payments timely for Veterans incarcerated in Federal, state, and local penal institutions. Federal law requires VBA to reduce C&P benefits for Veterans incarcerated for more than 60 days in a Federal, state, or local penal institution. VARO and Pension Management Center (PMC) staff did not consistently take action to adjust C&P benefits for Veterans incarcerated in Federal penal institutions. Specifically, based on Federal incarceration data ranging from May 2008 through June 2015, VBA did not adjust veterans' C&P benefits, as required, in an estimated 1,300 of 2,500 cases (53 percent), which resulted in improper payments totaling approximately $59.9 million. Without improvements, OIG estimated VBA could make additional improper benefit payments totaling about $41.8 million for Federal incarceration cases from FY 2016 through FY 2020.

VARO and PMC staff also did not take consistent and timely action to adjust C&P benefits for veterans incarcerated in state and local penal institutions. Based on incarceration notifications received from March 2013 to August 2014—the most current data available at the time of OIG's audit—VBA did not effectively adjust veterans' C&P benefits in an estimated 3,800 of 21,600 state and local incarceration cases (18 percent), which resulted in significant delays and improper payments totaling approximately $44.2 million. Without improvements, OIG estimated VBA could make additional improper benefit payments totaling about $162 million for state and local incarceration cases from FY 2016 through FY 2020. In general, VBA did not place a priority on processing incarceration adjustments because VBA did not consider these non-rating claims to be part of the disability claims backlog. Both VBA Central Office and VARO staff consistently reported that incarceration adjustments were not a high priority.

OIG also identified improper payments during its review of VBA's SMC Housebound Benefits (Report Number 15-02707-277, issued September 29, 2016). The OIG reviewed whether VBA granted entitlement to all statutory housebound SMC benefits for veterans with a disability rated at 100 percent and additional disabilities independently rated at 60 percent. OIG also assessed whether VBA accurately processed SMC for veterans receiving compensation at the housebound rate. VBA's processing of SMC housebound benefits needs improvement. OIG identified processing inaccuracies in 45 of 250 cases where Veterans were entitled to statutory housebound benefits, resulting in estimated underpayments of $110.1 million through February 2015. Generally, errors occurred because staff overlooked the issue and VBA's electronic

reminder was ineffective. In addition, VBA did not accurately process 127 of 247 cases where Veterans were being paid at the housebound rate. For cases with a combined evaluation of 90 percent or less, errors resulted in estimated overpayments of $44.3 million through February 2015. In many instances, the errors were due to ineffective training and a multi-step process in VBA's electronic system. Together, these errors resulted in improper payments of $154.4 million through February 2015.

VA's Program Response
Estimated Resolution Timeframe: FY 2020
Responsible Agency Officials: Interim Assistant Secretary for Management and Interim Chief Financial Officer (Lead), Under Secretary for Health, and Acting Under Secretary for Benefits, Principal Executive Director of Office of Acquisition, Logistics, and Construction
Associated Strategic Goal: Empower Veterans to Improve their Well-being
Strategic Objective: Increase customer satisfaction through improvements in benefits and services delivery policies, procedures, and interfaces

Associated Performance Measure(s): No public-facing measures are associated with this issue.

The Inspector General raised concerns about the VA's compliance with IPERA in their report released on May 15, 2015, and VA provided a detailed response in the FY 2015 Agency Financial Report (http://www.va.gov/finance/docs/afr/2015VAafrSectionIII.pdf, pg. 86). VA continues to address root causes of improper payments through the IPERA Governing Board and individual program corrective actions developed to mitigate findings from the OIG's 2016 IPERA report issued May 13, 2016.

In 2015, VA saw a significant increase in our improper payment rates. This was due to VHA's continued incorporation of contract compliance [Federal Acquisition Regulations (FAR) and VA Acquisition Regulations (VAAR)] into their test plans for VA Community Care and Purchased Long-Term Services and Support. This increased improper payment rate has continued into 2016 as VHA improves testing methodology and educating staff on proper contract regulations.

As the OIG noted, elimination of VBA improper payments for VA benefits processing related to military drill pay offsets are hampered by the current statutory framework. Legislative changes, funding, and computer system changes will be required, and therefore VA is working with the Office of Management and Budget (OMB) to determine whether this significant reform has long-term potential for implementation.

To help mitigate identified compliance issues within learning institutions, VBA will deploy an outreach team to assess areas of vulnerability in non-compliant institutions. In addition, VBA is updating the School Certifying Official Handbook to include Standard Operating Procedures surrounding document retention and ensuring available documentation is provided timely for IPERA requests.

After reviewing the data on Federal incarcerations from May 2008 through June 2015, VBA identified a backlog of cases and initiated a review to process potential award adjustments. In the first quarter of FY 2016, VBA began a data-matching agreement with the Bureau of Prisons.

VBA deployed systemic changes to the Veterans Benefits Management System-Rating (VBMS-R) application on June 17, 2016, which included new programming that prevents staff from completing decisions without considering potential eligibility to statutory housebound benefits any time a Veteran has a single 100 percent evaluation. Rating Veteran Service Representatives and Decision Review Officers were required to take mandatory training on evaluating higher level of Special Monthly Compensation. This training was completed on July 1, 2016.

Utilizing proactive identification of root causes of improper payment, Compensation Service (CS) provided focused training to regional offices and deployed a Rules-Based Processing System for dependency claims to improve claim accuracy through automation. In FY 2016, VBA was able to reduce the number of pending dependence claims by approximately 50 percent.

Pension Service conducted site visits to assist the Pension Management Centers in identifying or detecting any operational deficiencies that may have negatively impacted the accurate and efficient processing and authorization of pension related claims. The site visit team also addressed training related issues and provided awareness of how incorrect actions taken on pension claims impacts IPERA.

Reducing improper payments is a high priority for VA's overall effort to strengthen financial management. VA is committed to achieving compliance with IPERA and remediating improper payments as part of our stewardship of taxpayer dollars.

VA continues to strengthen its efforts to ensure the improper payment definition is consistently applied, improve the accuracy and completeness of testing, develop and implement effective corrective actions, and increase awareness and accountability throughout the Department. Leadership has increased communication to clarify roles and responsibilities with Senior Accountable Officials to strategically strengthen program integrity by addressing vulnerabilities in programs, implementing effective corrective actions, and tracking issues to resolution.

OIG Sub-Challenge #3B: Improving Management of Appropriated Funds (OM, OIT, VHA)

In September 2012, OIG issued *Administrative Investigation of the FY 2011 Human Resources Conferences in Orlando, Florida* (Report Number 12-02525-291, issued September 30, 2012), which identified inadequate controls resulting in wasteful spending. OIG conducted an audit of FY 2014 conferences to assess the adequacy of the actions VA took to address identified control weaknesses identified in the September 2012 Administrative Investigation.

In OIG's report *Audit of VA's Conference Management for Fiscal Year 2014* (Report Number 15-01227-129, issued April 6, 2016), policy and oversight weaknesses were identified that could undermine the cost-effectiveness of conferences and increase the risk of inappropriate spending. VA organizations did not comply with policy for 11 of 12 randomly selected FY 2014 conferences. VA organizations did not prepare Conference Packages in accordance with policy for 10 conferences with budgets totaling approximately $11.6 million. VA organizations

also did not prepare Final Conference Reports in accordance with policy for 11 of 12 conferences, with expenditures totaling approximately $7.9 million. Weaknesses in policy implementation occurred because VA did not issue adequate guidance, implement adequate oversight procedures, or provide adequate accountability to ensure VA organizations complied with conference policies. As a result, these weaknesses contributed to VA reporting approximately $3.9 million in conference expenditures to Congress that could not be adequately traced to source documentation to verify their accuracy and appropriateness.

OIG also completed a report *Audit of VHA's Non-VA Medical Care Obligations* (Report Number 14-02465-47, issued January 12, 2016), that assessed whether VHA adequately managed non-VA medical care miscellaneous obligation cost estimates and related management and system controls. The Non-VA Care (NVC) Program expenditures of about $4.8 billion included $1.9 billion in obligated funds that remained unspent as of the end of FY 2013. Significant under or over obligation of these program funds could affect overall VHA operations.

VHA medical facilities did not adequately manage the obligations used to purchase NVC. From October 1, 2013, through March 31, 2015, VHA medical facility officials determined that they had overestimated the funds needed to pay for these services by about $543 million. The unnecessary obligation of these funds prevented VHA from using $543 million of the $1.9 billion (29 percent) obligated for NVC for any purpose during FY 2013. Reducing the over obligation of NVC funds from about 29 to 10 percent would have freed up about $358 million to acquire additional NVC services. This occurred because VHA did not:

- Provide the facilities with adequate tools to reasonably estimate the costs of NVC services;
- Require medical facility staff to routinely adjust cost estimates for individual authorized services to better reflect actual costs;
- Ensure NVC staff adjusted the estimated amount of obligated funds in the VistA after payments are complete; or
- Require facilities to analyze the accuracy of prior year obligation balances.

Additionally, in March 2015, U.S. Senator Mark Warner requested the OIG evaluate the merit of an allegation that a task order to develop e-learning courses for the supply chain workforce was improperly terminated. In *Review of the Alleged Improper Termination of the e-Learning Task Order* (Report Number 15-02776-240, issued September 19, 2016), OIG did not substantiate that VA's decision to terminate the e-learning task order was without just cause, as the Federal Acquisition Regulation (FAR) provides broad latitude for termination for convenience by the Government. However, OIG did determine that the Veterans Affairs Acquisition Academy did not properly plan and coordinate the e-learning task order with the Office of Logistics and Supply Chain Management officials. Consequently, it did not meet the program office's training needs. Had the Veterans Affairs Acquisition Academy taken the appropriate planning and coordination steps, it may have mitigated the termination risk and saved VA approximately $1.9 million for supply management courseware that was not completed.

OIG also substantiated an allegation that the Detroit VAMC had not installed and utilized 282 of 300 purchased televisions or their associated accessories in *Review of Alleged Waste of Funds at the VA Medical Center in Detroit, Michigan* (Report Number 16-02729-350, issued August 9, 2016). The facility acquired the equipment in September 2013 as part of a project to replace the patient television system in the facility, but as of April 2016, 282 of the televisions and associated accessories were in storage. Despite having all the televisions

and accessories on hand for more than 2 years, the facility was unable to install the items in the patient rooms because they did not meet the design specifications identified in the patient television system architect and engineer (AE) services contract.

OIG determined Detroit VAMC officials did not communicate with the AE contractor in a timely manner to ensure the televisions purchased were compatible with the design and specifications of the project. As a result, the Detroit VAMC issued a contract modification for $19,052 to adjust the design and specifications of the project to support the televisions purchased. The televisions and related accessories should have been purchased closer to award of the construction contract. By purchasing these items more than 2 years before a construction contract to install them was awarded, the facility exposed itself to unnecessary financial risk in the event it does not proceed with the patient television system upgrade project. As of April 2016, the facility had not yet awarded a contract to install these televisions. Further, by purchasing too early in the process the facility allowed valuable warranties to expire, increasing the risk of incurring additional expenses to replace any faulty televisions.

VA's Program Response
Estimated Resolution Timeframe: 2017
Responsible Agency Official: Interim Assistant Secretary for Management and Interim Chief Financial Officer
Associated Strategic Goal: Manage and Improve VA Operations to Deliver Seamless and Integrated Support
Strategic Objective: Enhance Productivity and Improve Efficiency of the Provision of Veteran Benefits and Services
Associated Performance Measure(s): No Public Facing Measures are Associated with this Issue

VA is committed to financial management excellence through sound stewardship of taxpayer dollars. Thus, VA constantly strives to improve our financial practices and policies. In OIG's Audit of VA's Conference Management for Fiscal Year (FY) 2014 (Report Number 15-01227-129, issued April 6, 2016), VA's compliance was assessed with an outdated policy that was replaced in March of 2015. As such, many of the issues of noncompliance identified were the result of a complex and burdensome policy that did not accommodate how conferences were organized or executed across VA. Further, OIG's reported noncompliance with the outdated policy did not identify any wasteful spending, abuse or misuse of funds. Prior to the OIG's review, VA had developed an updated policy which maintained accountability, while ensuring it could be practicably applied in the development and approval of conferences.

VA acknowledges that its new policy did not specifically address those conferences held multiple times within a year or offered at Government-owned facilities. The policy will be further updated to provide additional clarity to the process and align with recent clarification from the Office of Management and Budget. VA takes its planning and execution of conferences seriously, and believes the new policy and procedures will ensure proper spending and accountability.

VA continues to make progress in addressing findings from the audit of VHA's Non-VA Medical Care Obligations (Report Number 14-02465-47, issued January 12, 2016). The Office of

Community Care's Purchased Care program has enhanced the Fee Basis Claims System (FBCS) cost estimation tool to assist VA medical centers (VAMCs) in developing more accurate authorization estimates. In addition, on a daily and monthly basis, multiple reports are generated by Purchased Care and distributed to the VAMCs to identify potential issues with authorization estimates. In FY 2016, the Deputy Under Secretary for Health for Operations and Management added a requirement for all Veterans Integrated Service Networks (VISNs) to certify that their VAMCs have completed a review of the previous months' FBCS authorization estimates for accuracy.

VA has also improved the reconciliation process between FBCS and the Financial Management System (FMS) by requiring VAMCs to reconcile FBCS authorization estimates to corresponding FMS obligations and payments on a monthly basis. VISN Directors certify monthly that the reconciliation is performed.

In March of 2015, Senator Mark Warner requested that OIG evaluate the merit of an allegation that a task order to develop e-learning courses for the supply chain workforce was improperly terminated; VA is awaiting final publication of the OIG report and any related recommendations.

VA concurred with the recommendations on the site-specific report, Review of Alleged Waste of Funds at the VA Medical Center in Detroit, Michigan (Report Number 16-02729-350, issued August 9, 2016), and has developed and implemented a plan to utilize the purchased televisions. A contract for the installation of the televisions cited in the report was awarded in June of 2016, and the installation project began in July of 2016.

VA takes our financial responsibilities seriously. Maintaining the public's trust of our financial stewardship remains one of our highest priorities.

OIG Sub-Challenge #3C: Improving the Timeliness of Payments to Purchased Care Providers (VHA)

In 2016, OIG testified before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives, about the challenges VA faces in administering its purchased care programs. From August 2014 through February 1, 2016, VA has spent $224.4 million on the VCP. VA has reimbursed Health Net and Tri West $171.4 million of $224.4 million (76 percent) for administering the program and $53.0 million of $224.4 million (24 percent) for medical services provided to Veterans. OIG's audits and reviews have shown that VA faces challenges in administering its purchased care programs, not only with access to care, but with proper expenditure of funds, and timely payment of providers. VA lacked adequate processes to manage these funds and oversee program execution. While purchasing healthcare services from non-VA providers may afford VA flexibility in terms of expanded access to care and services that are not readily available at VA medical facilities, it also poses a significant risk to VA when adequate controls are not in place. With non-VA healthcare costs of about $6 billion in FY 2015 and future costs expected to increase, VA needs to improve program controls over timely payments. Without adequate controls, VA's consolidation plan is at increased risk of not achieving its goal of delivering timely and efficient healthcare to Veterans.

OIG determined veterans faced significant barriers accessing medical care through the VCP. These barriers included cumbersome authorization and scheduling procedures, insufficient provider networks, and potential liability for treatment costs. These barriers occurred because VCP implementation was inadequately planned and administrative burdens placed on network

providers and low reimbursement rates discouraged their participation. As a result, from November 1, 2014, through September 30, 2015, very few veterans received care through the VCP. Only 13 percent of veterans who were waiting more than 30 days for VA care utilized the VCP. Those who successfully navigated the VCP's cumbersome procedures waited an average of 45 days to receive care. Also, VA spent about $165.2 million administering the program compared to $15.1 million providing medical care for veterans. VA is currently planning a new acquisition to replace the existing VCP contracts. For this new acquisition to be successful, VA will need to ensure OIG's recommended changes are addressed in a timely manner.

VA's Program Response
Estimated Resolution Timeframe: 2016
Responsible Agency Official: Under Secretary for Health
Associated Strategic Goal: Manage and Improve VA Operations to Deliver Seamless and Integrated Support
Strategic Objective: Enhance productivity and improve efficiency of the provision of Veteran benefits and services. Evolve VA information technology capabilities to meet emerging customer service/empowerment expectations of both VA customers and employees.
Associated Performance Measure(s): No public-facing measures are associated with this issue.

VA Community Care has taken steps to improve claims processing timeliness. As of July 22, 2016, 82.54 percent of all clean claims were aged less than 30 days as compared to 1 year ago when 70.45 percent of all claims were aged less than 30 days. This amounts to a 12 percent improvement over that period.

The Claims Adjudication and Reimbursement (CAR) program has made significant strides in reducing the aged inventory and has implemented standardized processes across the country to ensure claims are processed consistently with the same rules. CAR, in conjunction with Program Oversight and Informatics staff, has developed a "Dashboard" for field Supervisors to view claim level detail and staff member detail. This capability helps ensure that the oldest claims are being processed.

CAR has also established teams to work on the "other than clean claims" and "unauthorized claims". Such claims have gone from 56.95 percent in July 2015 to 75.85 percent, July 2016, aged less than 45 days in age. These claims are much more complicated and require specific eligibility to be met to approve these claims for payment.

CAR continues to monitor claims status and standardize claims processes in order to increase claims processing timeliness and reduce claims inventory.

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 of support service contracts, PC3, and allegations regarding other contracts identified 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 FAR 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.

OIG Sub-Challenge #4A: Improving Contracting Practices (OALC, VHA)

The replacement of the Denver VAMC, Eastern Colorado Health Care System (Denver project) has experienced significant, and unnecessary, cost overruns and schedule slippages. The project dates back to the late 1990s. This was in response to the region's growth in the veteran population and the need to replace an aging and inadequate facility built in 1951. VA's 2009 acquisition plan initially estimated the Denver project would cost approximately $536.6 million to build with construction finished in 2013. The project's $800 million budget included items such as the cost of land acquisition, design, construction, and consultant services. Congress provided appropriations between 2004 and 2012 to cover these costs. However, current estimates for the project place the final cost at $1.675 billion or more than twice VA's FY 2009 approved project budget.

The construction portion of the project was a little more than half completed and is estimated to be completed approximately two years after the new contract was awarded to Kiewit-Turner on October 30, 2015. VA issued a task order to the U.S. Army Corps of Engineers to provide oversight of this new contract. According to a VA official, activation of the hospital is estimated to take up to an additional six months and approximately $315 million. This means Veterans will not likely be served by a fully functioning facility before mid to late 2018 or almost 20 years after VA identified the need to replace and expand its aging facility in Denver.

The Denver project's escalating cost estimates and schedule slippages are the result of poor business decisions, inexperience with the type of contract used, and mismanagement by VA senior leaders. It is now too late for VA to undo the negative effects of its poor management decisions concerning the Denver project because it is a little more than half completed. Although, VA contracted the U.S. Army Corps of Engineers to manage the Denver project there are "lessons learned" that VA can apply to VA's remaining and future construction projects.

In *Review of Alleged Mismanagement of the Ambulette Services at the New York Harbor Healthcare System* (Report Number 15-04945-331, issued August 18, 2016), the allegation that VA acquisition personnel mismanaged the award of ambulette services task orders at the New York Harbor Healthcare System (NYHHS) was substantiated. Specifically, acquisition personnel improperly awarded two task orders for ambulette services when the contractor's Federal Supply Schedule contract did not offer the services VA was seeking. In addition, the

contracting officer's award determination for the re-solicited requirement was not clearly justified. Further, acquisition personnel did not document all pertinent contracting actions in VA's Electronic Contract Management System (eCMS). This occurred because VA's Integrated Oversight Process (IOP) reviews designed to improve contract quality were not always completed. While the IOP was in place, contracting staff did not conduct required reviews for the first two task orders. If performed, these pre-award reviews may have revealed the vendor did not offer the services VA was seeking. Further, personnel turnover caused confusion as to who should ensure contract documentation was included in eCMS. As a result, acquisition personnel put VA at risk for protests and payment to protesters for restitution.

VA's Program Response
Estimated Resolution Timeframe: 2016
Responsible Agency Official: Principal Executive Director, Office of Acquisition, Logistics, and Construction
Associated Strategic Goal: Manage and Improve VA Operations to Deliver Seamless and Integrated Support
Strategic Objective: N/A
Associated Performance Measure(s): There are no public-facing measures associated with this issue

In regard to OIG's review of VA's National Acquisition Center's (NAC) procurement strategy used under the DoD Digital Imaging Network-Picture Archival Communication System contract (DIN-PACS), OALC has not received a copy of the draft report to provide comment. As summarized by OIG, in the text above, the following allegations were not substantiated: the manipulation of technical evaluations, excessive equipment purchases, or an award that was made 30 percent higher than recommended. OALC welcomes the opportunity to review the draft report, *Review of Alleged Contract Practices at the National Acquisition Center (NAC)* and any specific findings or recommendations when the draft report becomes available.

The Office of Inspector General previously raised concerns regarding the replacement of the Denver Medical Center in a draft report released in May 2016. VA provided a detailed response to the OIG in June 2016. An excerpt from our response follows:

The Office of Acquisition, Logistics, and Construction (OALC) agrees with the findings of the OIG draft report and acknowledges that it is too late to undo the mistakes made on the Denver project. OALC has learned from those mistakes and has embarked on an enterprise-wide effort to improve our processes. As indicated in the report, OALC and the Office of Construction and Facilities Management (CFM) in particular have put in place sound construction management processes based on best practices from private industry and other Federal agencies; lessons learned, including those from the Denver project; and recommendations made to the Department of Veterans Affairs (VA) from various stakeholders including the Office of the Inspector General (OIG), the Government Accountability Office, the United States Army Corp of Engineers (USACE), and construction industry partners. These process improvements will help ensure proper execution of our major construction projects and future success in the construction program, allowing VA to provide increased access to care for Veterans and their families around the country.

In regard to the report, *Review of Alleged Mismanagement of Ambulette Services Contract at the VA New York Harbor Healthcare System,* VHA Procurement and Logistics has initiatives to implement contracting officer warrant boards to assess employee skills prior to issuing contracting officer warrants. VHA revised the contract award review thresholds and processes to align risk with more robust review.

OIG Sub-Challenge #4B: Improving Purchase Card Practices (OALC, VHA)

In April 2014, OIG's OHI briefed VA New Jersey Health Care System (VANJHCS) leadership regarding the results of a criminal investigation of purchase card abuse in the Engineering Service. In OIG's report *Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System* (Report Number 11-00826-261, issued April 26, 2016), the objective was to determine whether the inappropriate practice of split purchasing occurred in services other than the Engineering Service at VANJHCS.

OIG found the inappropriate practice of split purchasing extended beyond the Engineering Service at VANJHCS. OIG determined VANJHCS employees split purchases in 64 of the 76 purchase card transactions (84 percent) reviewed, totaling $125,270. This included 19 purchase cardholders working in 6 different services. Based on the sample results, OIG estimated that VANJHCS staff inappropriately made about 4,750 split purchases totaling approximately $8.9 million from December 2012 through May 2014. This occurred because of a disregard for internal controls that are an integral part of every Federal Government purchase card program. Additionally, management did not provide effective oversight and did not hold VANJHCS purchase cardholders, their supervisors, and the approving officials accountable for policy violations.

OIG estimated that split purchasing resulted in approximately $8.9 million in unauthorized commitments and increased the risk of fraud, waste, and abuse of taxpayer resources at VANJHCS. The lack of oversight and ineffective controls also prevented VANJHCS management from determining whether VANJHCS received all purchased goods and services. Management needs to take immediate corrective action and make long-term improvements to ensure sound financial stewardship of taxpayer resources.

VA's Program Response
Estimated Resolution Timeframe: On-going
Responsible Agency Official: Principal Executive Director, Office of Acquisition, Logistics, and Construction
Associated Strategic Goal: Manage and Improve VA Operations to Deliver Seamless and Integrated Support
Strategic Objective: N/A
Associated Performance Measure(s): There are no public-facing measures associated with this issue

The VA New Jersey Health Care System (VANJHCS) Purchase Card Coordinator terminated 18 purchase cards that were issued to 18 different individuals to decrease the possibility of misuse. In addition, they centralized their purchasing program and hired one full-time employee assigned to the Chief of Logistics Service, who will manage the purchasing program. Purchase Card holders are currently required to complete the training, which is tracked in the Talent Management System (TMS). Purchase card training topics include unauthorized commitments,

GSA SmartPay, quarterly reconciliations, procurement integrity, and online IFCAP training. TMS training is currently tracked and the Purchase Card Coordinator sends out monthly email reminders to the Service Chief and Purchase Card Holder. In addition, to ensure stronger oversight, VANJHCS Logistics Service, with assistance from the VA New York/New Jersey Veterans Integrated Service Network, reviewed all items used in the engineering shops. VANJHCS decided that all items would have master numbers in order to have these items added to the Generic Inventory Packages; and based upon usage, they will either be standard or on-demand. VANJHCS Logistics Inventory Management Specialists are assisting with completion. VANJHCS has encouraged each Service to review their recurring purchases in order to establish contracts for these items. In addition, the facility is currently reviewing all actual occurrences of split orders that have resulted in unauthorized commitments and will continue the ratification process as these are identified.

VHA Procurement is responsible for administration of the purchase card program within VHA. Split requirements are a continuous challenge for any purchase card program. VHA Procurement has collaborated with the Office of Management's Office of Internal Controls to identify and correct incidence of split requirements. With regard to the erroneous input of FPDS data, the situation was a one-time mistake in judgment by an employee. The action was corrected and no further strategic improvement was required.

VHA Procurement will continue to work the VA Office of Internal Controls to reduce the incidence of split requirements.

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 counter-productive. 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 Assistant Secretary and Chief Information Officer, 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, and ending Veteran homelessness.

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 2015 CFS audit, OIG's independent auditor reported that VA did not substantially comply with requirements of the FFMIA of 1996. While providing an unqualified opinion on the CFS, the independent auditor continues to identify IT security controls as a material weakness. Furthermore, CFS auditors noted material weaknesses related to: (1) contract

procurements, undelivered orders, and account reconciliations; (2) purchased care processing; and (3) key processes supporting accurate financial reporting.

OIG work indicates VA has only made marginal progress toward eliminating the material weakness and remediating major deficiencies in IT security controls. OIT also has not fully implemented competency models, identified competency gaps, or created strategies to ensure its human capital resources can support VA's current and future mission requirements with necessary IT enhancements or new initiatives. Despite implementation of the Project Management Accountability System and VA's transition to the Veteran-focused Integration Process framework to ensure IT oversight and accountability, the Department 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, thus 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. OIG's recent work on the CFS audit supports OIG's annual Federal Information Security Modernization Act (FISMA) assessment. During FY 2015, OIG reported that 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. In FY 2015, the VA's Chief Information Officer formed an Enterprise Cybersecurity Strategy team that was charged with delivering an enterprise cybersecurity strategic plan. The plan was designed to help VA achieve transparency and accountability while securing veteran information. The team's scope included management of current cybersecurity efforts, as well as development and review of VA's cybersecurity requirements from desktop to software to network protection.

As FISMA work progressed, OIG noted more focused VA efforts to implement standardized information security controls across the enterprise. OIG also noted improvements in role-based and security awareness training, a 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 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, VAROs, 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 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 tasked with implementing corrective actions.

OIG's report *VA's Federal Information Security Modernization Act Audit for Fiscal Year 2015* (Report Number 15-01957-100, issued March 15, 2016), 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 has over 9,500 system security risks and corresponding Plans of Action and Milestones (POA&Ms) that still need to be remediated to improve the overall information security posture. More importantly, OIG continues to identify significant technical weaknesses in databases, servers, and network devices that support the transmission of sensitive information among VA facilities. The FY 2015 FISMA report provided 31 current recommendations to the Assistant Secretary for Information and Technology to improve VA's information security program. The report also highlighted 4 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:

- Address security-related issues that contributed to the IT material weakness reported in the FY 2015 CFS audit of the Department;
- Successfully remediate high-risk system security issues in its POA&Ms; and
- Establish effective processes for evaluating information security controls via continuous monitoring and vulnerability assessments.

In December 2014, OIG's Hotline Division received an allegation that ProCare Home Medical, Inc., (ProCare), located in Anchorage, Alaska, was improperly storing and sharing VA sensitive data on contractor personal devices in violation of Federal information security standards. More specifically, the complainant alleged that ProCare was allowing its employees to use personal computers and phones to access the company computer system and download VA sensitive data to include Veterans' personal health information. OIG substantiated the allegation that ProCare, according to its staff, accessed electronic sensitive Veteran data with its personal computers from home through an unauthorized cloud-based system without encryption controls in *Review of Alleged Contractor Information Security Violations in the Alaska VA Healthcare System* (Report Number 15-01994-238, issued July 12, 2016). OIG also noted that personnel or malicious users could potentially use personal devices on an unauthorized wireless network to access sensitive veteran information. Additionally, OIG determined that ProCare was storing sensitive hard copy and electronic Veteran information in an unsecured manner at their facility. OIG recommended the VA Northwest Health Network management assign a local contracting officer representative and information security officer to provide oversight of Alaska VA Healthcare System contractors. OIG also recommended the VA Northwest Health Network

management, in conjunction with the Assistant Secretary for Information and Technology, conduct a site assessment of ProCare information security controls to ensure compliance with VA information security requirements.

VA's Program Response
Estimated Resolution Timeframe: December 2017
Responsible Agency Official: Assistant Secretary for the Office of Information and Technology (OI&T)
Strategic Goal – Manage and Improve VA Operations to Deliver Seamless and Integrated Support
Strategic Objective – Evolve VA information technology capabilities to meet emerging customer service/empowerment expectations of both VA customers and employees
External Facing Measure – There are no public-facing measures associated with this issue

VA is committed to protecting all Veteran information and VA data, and limiting access to only those with the proper authority. Meeting this commitment requires a comprehensive strategic approach that spans VA and the cyberspace ecosystem in which Veterans, VA, and VA's partners operate. In response, VA created the Enterprise Cybersecurity Strategy, which is predicated on protecting and countering the spectrum of threat profiles through a multi-layered defense in depth model spanning eight domains.

As part of its work, the Enterprise Cybersecurity Strategy Team created individual Plans of Action (POAs) to address the 35 recommendations provided by the OIG as a result of the FY 2015 Federal Information Security Management Act Report. The goal of this effort is to remediate the VA's longstanding Material Weakness in information security while also improving the organization's security posture in support of protecting Veteran data. VA leadership – including the Secretary of the Department of Veterans Affairs – are tracking the status of the 35 OIG recommendations' POAs on a weekly basis to monitor progress of the actions taken by VA to address the identified weaknesses. These plans are part of a comprehensive Integrated Master Schedule with specific timelines to support closure of the identified weakness. As of this date, three of these plans are completed and awaiting final verification. The remaining 32 are projected for completion no later than December 2017.

With regard to improving access control, VA now has the ability to ensure security compliance for the computers used by all remote users who connect to the VA network using their government furnished equipment, due to our 3rd quarter, FY 2015 implementation of Network Access Control (NAC) for virtual private network connections. Beyond this capability, VA is planning to expand the above NAC capability, via efforts inextricably linked to the DHS Continuous Diagnostics and Monitoring (CDM) Program (CDM Phase 2), with an expansion of the asset discovery capability. This initiative is planned to be fully implemented by the end of July 2017. Further enhancement of the NAC capability would expand upon the asset discovery capability and is tentatively scheduled to be deployed by the end of 2018. Since the 3rd quarter of FY 2015, VA has also reduced the number of accounts with elevated privileges by 95 percent, from 267,000 to approximately 10,000, and remediated 23 million critical and high vulnerabilities as of July 2016. Through close partnership with the clinical staff in VHA, the new Chief Information Security Officer, with concurrence of the CIO, has rescinded prior Personal Identification Verification (PIV) exemptions and is now requiring 100% (PIV) participation, to

include those providing patient care. OI&T and VHA are implementing a joint collaborative surge effort to better implement technical enforcement of PIV compliance beginning August 8, 2016. VA is also committed to improving its management of medical devices and has established a review process for ensuring appropriate Medical Device Isolation Architecture Access Control List (ACL) reviews have been applied. To date, 55% (2234 of 4061) ACLs have been remediated to provide better security to Veterans.

VA is not satisfied with the status quo and is committed to finding significant ways to remediate each deficiency that is highlighted within the MMC report. By the end of 2016, VA strives to accomplish the following:

- Enable two-factor authentication using PIV cards for 75% of VA personnel by September 30, 2016.
- Complete 15 cyber security plans of action by December 31, 2016 to address OIG recommendations.
- Eliminate three Material Weakness findings by December 31, 2016, leading to marked improvements in System Development/Change Management Controls, Continuous Monitoring, and Contractor Systems Oversight.
- Implement improvements in systems auditing during the 1st quarter, FY 2017, to provide increased visibility into security events and system alerts requiring attention.
- Continue to decrease the number of elevated privilege accounts to a target in keeping with the organizational risk tolerance.

As VA moves forward in the implementation of an enterprise security information and event management deployment, OI&T has implemented organizational improvements such as updating the firewall policy and updating the concept of operations related to the automated collection and analysis of application and systems audit logs. In addition to providing weekly status reports on key cybersecurity metrics to the CIO, OI&T is also in the process of implementing an IT dashboard, which will provide near-real-time situational awareness for VA IT executives on cybersecurity performance measurements and trends.

While VA still has more work to do to fully address all cybersecurity needs, the Department has made strides toward the future state and developed data-based performance measurement to demonstrate progress toward a number of goals, for both internal and external oversight purposes.

OIG Sub-Challenge #5B: Improving Compliance with Federal Financial Management Improvement Act (OIT)

FFMIA requires agencies to implement and maintain financial systems that comply substantially with Federal financial system requirements, applicable Federal accounting standards, and the U.S. Standard General Ledger (USSGL) at the transaction level. The OIG's independent financial statement auditors reported that VA's financial management systems did not substantially comply with Federal financial management systems requirements, and the USSGL at the transaction level. In particular, the auditors reported the following:

- VA's core accounting system—Financial Management System (FMS)—has functional limitations that were further exacerbated by operational and security vulnerabilities as VA continued to operate FMS on a database no longer supported by the vendor.

- VA's Integrated Funds Distribution Control Point Activity, Accounting and Procurement System (IFCAP) is a module within VistA that is used by VHA, contracting officers, and other VA personnel to initiate and authorize purchase of goods and services, as well as to accumulate vendor invoices for payment. Because the commitment accounting module was not activated during the implementation of FMS, obligations in FMS are recorded based on approved purchase requisitions or Miscellaneous Obligating Documents (1358s) from IFCAP instead of valid contracts or purchase orders. Further, transactions initiated and recorded in IFCAP cannot be centrally and completely reconciled to those in FMS or to the procurement source documentation maintained in eCMS.
- VistA does not provide management with the ability to effectively and efficiently monitor nationwide Medical Care Collection Fund activities at the transaction level. Consolidated Patient Accounting Center personnel cannot generate combined reports for all facilities under their purview. Reports are generated separately for individual medical centers, which leads to inefficiencies in operations and revenue management. Further, a nationwide report at a sufficient level of detail cannot be generated. Reconciliation of revenue transactions to collections and the supporting audit trail is more complicated. Additionally, VistA is not able to produce a consolidated accounts receivable aging report at a sufficient level of detail. Management does not have the tools to properly assess the reasonableness of its allowance for loss provision or perform a retrospective analysis to ascertain the reasonableness of its allowance methodology.
- Fee Basis Claims System (FBCS) is used to manage the authorization and payment processes for VHA's purchase care program. FBCS sits "on top" of VistA and runs in a decentralized manner similar to VistA. Transactions initiated in FBCS were not completely reconciled to those in IFCAP and FMS.
- eCMS is an intranet-based contract management system mandated by VA policy. VA does not utilize eCMS to electronically process the approval and reviews performed for its acquisitions.
- Regarding noncompliance with the USSGL at the transaction level, budgetary execution transaction code and interface issues resulted in incorrect data in accounts that have long remained unresolved in FMS. Significant journal entries were needed to correct the balances. FMS also lacked functionality to meet U.S. Department of the Treasury reporting requirements related to intragovernmental transactions, which created the need for significant journal entries.

The auditors reported that noncompliance with FFMIA was due to VA's complex, disjointed, and legacy financial management system architecture that has continued to deteriorate and no longer meets increasingly stringent and demanding financial management and reporting requirements. In VA's 2015 AFR, the Secretary stated that the Department will pursue the possibility of either upgrading its current financial system or migrating to a shared service provider.

VA's Program Response
Estimated Resolution Timeframe: 2021
Responsible Agency Official: Assistant Secretary for Information and Technology and Chief Information Officer, and Interim Assistant Secretary for Management and Interim Chief Financial Officer
Associated Strategic Goal: Manage and Improve VA Operations to Deliver Seamless and Integrated Support
Strategic Objective: Evolve VA Information Technology Capabilities to Meet Emerging Customer Service
Associated Performance Measure(s): No Public Facing Measures are Associated with this Issue

VA concurs that our legacy financial system does not fully comply with the Federal Financial Management Improvement Act (FFMIA). To address this significant challenge, VA has embarked on a major effort to replace our current financial system. VA plans to migrate to a Federal Shared Service Provider, as mandated by the Office of Management and Budget. This system modernization effort will resolve many of VA's current areas of noncompliance with FFMIA. As VA modernizes our financial system, we will assess the feasibility of updating other VA legacy feeder systems such as IFCAP, VistA, and eCMS. We will use this opportunity to re-engineer any outdated business processes. VA is committed to addressing long-standing financial system deficiencies and making our financial operations more efficient and effective.

APPENDIX A

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–Delay in Care of a Lung Cancer Patient, Phoenix VA Health Care System, Phoenix, Arizona
9/30/2016 | 14-00875-325 | Summary |

Healthcare Inspection–Surgical Service Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina
9/30/2016 | 15-00084-370 | Summary |

Healthcare Inspection–Alleged Inappropriate Opioid Prescribing Practices, Rutherford County Community Based Outpatient Clinic, Rutherfordton, North Carolina
9/29/2016 | 15-01982-113 | Summary |

Healthcare Inspection–Operating Room Reusable Medical Equipment and Sterile Processing Service Concerns, VA New York Harbor Healthcare System, New York, New York
9/29/2016 | 14-04274-418 | Summary |

OIG Determination of VHA Occupational Staffing Shortages
9/28/2016 | 16-00351-453 | Summary |

Healthcare Inspection–Lack of Follow-Up Care for Positive Colorectal Cancer Screening, New Mexico VA Health Care System, Albuquerque, New Mexico
9/27/2016 | 15-00018-349 | Summary |

Healthcare Inspection–Colorectal Cancer Screening Practices, Charlie Norwood VA Medical Center, Augusta, Georgia
9/22/2016 | 15-05328-373 | Summary |

Healthcare Inspection–Summarization of Select Aspects of the VA Pacific Islands Health Care System, Honolulu, Hawaii
9/22/2016 | 15-04655-347 | Summary |

Healthcare Inspection–Alleged Manipulation of Outpatient Appointments, Central Alabama VA Health Care System, Montgomery, Alabama
9/21/2016 | 15-03942-392 | Summary |

Healthcare Inspection–Emergency Department, Mental Health Service, and Suicide Prevention Training Concerns, Mann-Grandstaff VA Medical Center, Spokane, Washington
9/14/2016 | 15-03713-288 | Summary |

Healthcare Inspection–Administrative Response to Deaths and Quality of Care Irregularities, VA North Texas Health Care System, Dallas, Texas
8/26/2016 | 14-02725-316 | Summary |

Healthcare Inspection–Diagnosis and Treatment of a Patient's Adrenal Insufficiency at a Virginia VA Medical Center
8/25/2016 | 14-04505-346 | Summary |

Healthcare Inspection–Review of Primary Care Ghost Panels, Veterans Integrated Service Network 23, Eagan, Minnesota
8/11/2016 | 16-01708-340 | Summary |

Healthcare Inspection–Reported Primary Care Staffing at St. Cloud VA Health Care System, Veterans Integrated Service Network 23, Eagan, Minnesota
8/11/2016 | 15-05490-367 | Summary |

Healthcare Inspection–Psychiatry Partial Hospitalization Program and Management Concerns, Minneapolis VA Health Care System, Minneapolis, Minnesota
8/11/2016 | 14-04655-369 | Summary |

Healthcare Inspection–Cardiothoracic Surgery Program and Cardiac Catheterization Laboratory Concerns, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma
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Healthcare Inspection–Evaluation of Reported Wait Times, VA Greater Los Angeles Healthcare System, Los Angeles, California
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Healthcare Inspection–Access and Quality of Care Concerns, Phoenix VA Health Care System, Phoenix, Arizona, and Delayed Test Result Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota
6/23/2016 | 15-03867-287 | Summary |

Review of Allegation of Underutilized MRI Scanner in Waco, Texas
6/23/2016 | 15-01887-282 | Summary |

Review of VHA's Alleged Manipulation of Appointment Cancellations at VA Medical Center, Houston, Texas
6/20/2016 | 15-03073-275 | Summary |

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Healthcare Inspection–Mental Health Service Concerns at the Knoxville VA Outpatient Clinic, James H. Quillen VA Medical Center, Mountain Home, Tennessee
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Healthcare Inspection–Alleged Patient Safety Concerns, Miami VA Healthcare System, Miami, Florida
6/7/2016 | 14-03183-317 | Summary |

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Healthcare Inspection–Operating Room Concerns, Marion VA Medical Center, Marion, Illinois
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Healthcare Inspection–Alleged Improper Management of Dermatology Requests, Fayetteville VA Medical Center, Fayetteville, North Carolina
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Healthcare Inspection–Restraint Use, Failure To Provide Care, and Communication Concerns, Bay Pines VA Healthcare System, Bay Pines, Florida
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Healthcare Inspection–Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California
3/30/2016 | 14-04897-221 | Summary |
Healthcare Inspection–Alleged Employee Intimidation Related to Research Study Results, VA North Texas Health Care System, Dallas, Texas
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Healthcare Inspection–Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York
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Review of Alleged Mismanagement of Group Therapy Access at VA Outpatient Clinic, Austin, Texas
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Review of Alleged Untimely Care at VHA's Community Based Outpatient Clinic, Colorado Springs, Colorado
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Healthcare Inspection–Environment of Care and Safety Concerns in Operating Room Areas, Edward Hines Jr. VA Hospital, Hines, Illinois
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Healthcare Inspection–Emergency Department Concerns, Central Alabama VA Health Care System, Montgomery, Alabama
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Healthcare Inspection–Patient Care Deficiencies and Mental Health Therapy Availability, Overton Brooks VA Medical Center, Shreveport, Louisiana
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Healthcare Inspection–Point of Care Testing Program Concerns, Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio
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Healthcare Inspection–Access and Oversight Concerns for Home Health Services, Washington DC VA Medical Center, Washington, District of Columbia
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Healthcare Inspection–Alleged Program Inefficiencies and Delayed Care, Veterans Health Administration's National Transplant Program
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Healthcare Inspection–Poor Access to Care Allegedly Resulting in a Patient Death at the Oxnard Community Based Outpatient Clinic, VA Greater Los Angeles Healthcare System, Los Angeles, California
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Healthcare Inspection–Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona
10/15/2015 | 14-00875-03 | Summary |

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Statement of Gary K. Abe, Deputy Assistant Inspector General For Audits And Evaluations, Office Of Inspector General, Department Of Veterans Affairs, Before The Subcommittee On Health, Committee On Veterans' Affairs, United States House Of Representatives, Hearing On "Choice Consolidation: Improving VA Community Care Billing And Reimbursement" Read

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Statement of Linda A. Halliday, Deputy Inspector General, Office of Inspector General, Department of Veterans Affairs, Before The Subcommittee On Military Construction, Veterans Affairs, And Related Agencies, Committee On Appropriations, United States House Of Representatives, Hearing On The Office of Inspector General's Work and
FY 2017 Budget Request Read

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Statement of Larry Reinkemeyer, Assistant Inspector General For Audits And Evaluations (Designee), Office Of Inspector General, Department Of Veterans Affairs, Before The Committee On Veterans' Affairs, United States House Of Representatives, Hearing "A Continued Assessment Of Delays In Veterans' Access To Health Care" Read

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Statement of Michael J. Missal, Inspector General, Department of Veterans Affairs, Before The Committee On Homeland Security And Governmental Affairs, United States Senate, Field Hearing On "The Quality And Culture Of Care At The Department Of Veterans Affairs Medical Center in Tomah, Wisconsin" Read

OIG CHALLENGE #2: BENEFITS PROCESSING

Review of Alleged Manipulation of Quality Review Results at VA Regional Office, San Diego, California
5/9/2016 | 15-02376-239 | Summary |

Review of Alleged Misuse of eBenefits Accounts by a VA Supportive Services for Veteran Families Provider
5/5/2016 | 15-01951-281 | Summary |

Review of Alleged Manipulation of Quality Review Results at VA Regional Office, San Diego, California
5/9/2016 | 15-02376-239 | Summary |
Review of Alleged Lack of Audit Logs for the Veterans Benefits Management System
4/28/2016 | 15-03802-222 | Summary |
Review of Alleged Data Manipulation of Appealed Claims at VA Regional Office, Wichita, Kansas
4/26/2016 | 15-03581-204 | Summary |
Review of VBA's Alleged Inappropriate Prioritization of Appeals at VA Regional Office, Roanoke, Virginia
4/19/2016 | 15-02384-212 | Summary |
Review of Claims-Related Documents Pending Destruction at VA Regional Offices
4/14/2016 | 15-04652-146 | Summary |
Review of Alleged Shredding of Claims-Related Evidence at VA Regional Office Los Angeles, California
4/14/2016 | 15-04652-266 | Summary |
Review of Alleged Untimely Processing of VBA's Specially Adapted Housing Grants at the Regional Loan Center in Phoenix, Arizona
3/31/2016 | 15-01651-209 | Summary |
Follow-Up Audit of VBA's Internal Controls Over Disability Benefits Questionnaires
2/25/2016 | 14-02384-45 | Summary |
Follow Up Review on the Mismanagement of Informal Claims Processing at the VA Regional Office, Oakland, California
1/8/2016 | 14-03981-54 | Summary |
Review of Alleged Supervisory Influence To Expedite a Friend's Disability Claim at VA Regional Office, New York, New York
1/7/2016 | 14-04302-12 | Summary |
Review of Alleged Problems With VBA's Veterans Benefits Management System and Claims Processing
1/6/2016 | 14-04816-72 | Summary |
Review of Alleged System Access Failures for Veterans' to VBA's eBenefits Program
1/5/2016 | 14-04810-05 | Summary |
Review of Alleged Beneficiary Travel Irregularities at Hudson Valley HCS, Hampton & Lexington VAMCs
12/7/2015 | 15-02400-524 | Summary |

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Statement of Brent Arronte, Deputy 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 "1988 to 2016: VETSNET To VBMS: Billions Spent, Backlog Grinds On" Read

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Statement For The Record Of The Office Of Inspector General Department of Veterans Affairs, For The Subcommittee On Economic Opportunity, The Committee On Veterans' Affairs, United States House Of Representatives, Legislative Hearing Read

Congressional Testimony 6/15/2016
Statement of Brent Arronte, 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 "Investigating VA's Management Of Veterans' Paper Records" Read

OIG CHALLENGE #3: FINANCIAL MANAGEMENT

Audit of VBA's Post-9/11 G.I. Bill Tuition and Fee Payments
9/30/2016 | 14-05118-147 | Summary |

Review of Alleged Waste of Funds at VHA's Madison VA Medical Center
9/30/2016 | 15-00650-423 | Summary |

Review of VBA's Special Monthly Compensation Housebound Benefits
9/29/2016 | 15-02707-277 | Summary |

Review of VA's Alleged Improper Termination of the e-Learning Task Order
9/19/2016 | 15-02776-240 | Summary |

Review of Alleged Waste of Funds at the VA Medical Center in Detroit, Michigan
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5/12/2016 | 15-04252-284 | Summary |

Review of VA's Compliance With the Improper Payments Elimination and Recovery Act for FY 2015
5/12/2016 | 15-04252-284 | Summary |

Review of Alleged Misuse of Hurricane Sandy Funds at VA New York Harbor Healthcare System
1/6/2016 | 14-04152-370 | Summary |

Audit of VA's Conference Management for Fiscal Year 2014
4/6/2016 | 15-01227-129 | Summary |

Review of Alleged Wasted Funds in VHA's Southern Arizona VA Health Care System
2/18/2016 | 15-02413-55 | Summary |

Audit of VHA's Non-VA Medical Care Obligations
1/12/2016 | 14-02465-47 | Summary |

Audit of VA's Financial Statements for Fiscal Years 2015 and 2014
11/16/2015 | 15-01708-36 | Summary |

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Statement of Michael J. Missal, 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 "Investigating How VA Improperly Paid Millions To Incarcerated Veterans" Read

OIG CHALLENGE #4: PROCUREMENT PRACTICE

Review of VA's Award of the PC3 Contracts

9/22/2016 | 15-01396-525 | Summary |

Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System

9/21/2016 | 15-03706-330 | Summary |

Review of Alleged Mismanagement of the Ambulette Services at the New York Harbor Healthcare System

8/18/2016 | 15-04945-331 | Summary |

Audit of VA's Green Management Program Solar Panel Projects

8/3/2016 | 15-03688-304 | Summary |

Review of Alleged Improper Contract Awards in OI&T's Service, Delivery, and Engineering Office

7/12/2016 | 15-04231-223 | Summary |

Audit of Modular Ramps Purchased by the Malcom Randall VA Medical Center, Gainesville, Florida

6/29/2016 | 15-04248-305 | Summary |

Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System

4/26/2016 | 11-00826-261 | Summary |

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Statement of Quentin G. Aucoin, Assistant Inspector General For Investigations, Office of Inspector General, Department of Veterans Affairs, Before The Subcommittee On Oversight And Investigations, Committee On Veterans' Affairs, and The Subcommittee On Contracting And Workforce, Committee On Small Business, United States House Of Representatives, Joint Hearing On "An Examination Of Continued Challenges In VA's Vets First Verification Process" Read

OIG CHALLENGE #5: INFORMATION MANAGEMENT

Review of Alleged Breach of Privacy and Confidentiality of Personally Identifiable Information at the Milwaukee VA Regional Office

9/15/2016 | 16-00623-306 | Summary |

Review of Alleged Contractor Information Security Violations in the Alaska VA Healthcare System

9/7/2016 | 15-01994-238 | Summary |

Review of Alleged Lack of Access Controls for VA's Project Management Accountability System (PMAS) Dashboard

5/9/2016 | 15-02459-260 | Summary |

Review of Alleged Lack of Access Controls for VA's Project Management Accountability System (PMAS) Dashboard

5/9/2016 | 15-02459-260 | Summary |

VA's Federal Information Security Modernization Act Audit for Fiscal Year 2015

3/15/2016 | 15-01957-100 | Summary |

Review of Alleged Violation of VHA's Datawatch Data Pump Server Software License Agreement

1/5/2016 | 14-04761-09 | Summary |

Review of Alleged Noncompliance With Section 508 of the Rehabilitation Act on MyCareer@VA Web Site
4/7/2016 | 15-02781-153 | Summary |
Review of Alleged Unauthorized Devices and Equipment on Networks at VHA's Southern Arizona VA Health Care System
1/7/2016 | 14-04979-11 | Summary |

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Statement of Brent Arronte, Deputy Assistant Inspector, General for Audits and Evaluations, Office of Inspector General, Department of Veterans Affairs, Before The Subcommittee On Information Technology, Committee On Oversight And Government Reform, United States House Of Representatives, Hearing On "VA Information Technology And Cybersecurity Oversight" Read