Veterans Health Administration

*Audit of
Management Control
Structures for Veterans
Integrated Service Network
Offices*

**March 27, 2012
10-02888-129**

ACRONYMS AND ABBREVIATIONS

DUSHOM	Deputy Under Secretary for Health for Operations and Management
ECF	Executive Career Field
FMS	Financial Management System
FTE	Full-Time Equivalent Employee
OEF/OIF	Operation Enduring Freedom/Operation Iraqi Freedom
OIG	Office of Inspector General
PAID	Personnel and Accounting Integrated Data System
POC	Point of Contact
VA	Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Highlights: Audit of VHA's Management Control Structures for Veterans Integrated Service Network Offices

Why We Did This Audit

The Veterans Health Administration's (VHA) 21 Veterans Integrated Service Network (VISN) offices oversee 152 VHA healthcare facilities and over 1,220 related community based outpatient clinics, nursing homes, and Vet Centers throughout the country. The VISN offices merited review because of variations in their organizational structures, growth in their operations, and significant management discretion they have over field operations.

The audit assessed VISN office management controls and fiscal operations to determine if they promoted the proper stewardship of VA funds and resources; accountability, transparency, and effective oversight of VHA healthcare facilities; and compliance with VA policies. The audit resulted in two reports on the VISN offices. This report focuses on performance management and organizational structures and staffing.

What We Found

VHA lacked adequate management controls and needed to improve the quality of VISN office data to oversee and evaluate the effectiveness of VISN staff and organizational structures. First, despite improvements, VHA lacked assurance that its performance management system allowed the effective monitoring, evaluation, and comparison of VISN office performance. Second, VHA had not adequately monitored and managed the growth in the offices' organizational structures and staffing. These lapses occurred because VHA focused on the performance of its healthcare facilities and allowed VISN offices to operate autonomously. Consequently, VHA could not adequately justify the VISN offices' organizational structures and staffing levels and ensure that they provided optimal oversight, facilitated improved healthcare facility performance, and reflected the effective stewardship of VA funds.

What We Recommended

We recommended the Under Secretary for Health strengthen the VISN offices' performance management system and implement management controls over their organizational structures and staffing.

Agency Comments

The Under Secretary for Health concurred with our findings and recommendations and provided appropriate action plans. We will follow up on the implementation of VHA's corrective actions.

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INTRODUCTION

Objective

The audit evaluated whether Veterans Health Administration (VHA) and Veterans Integrated Service Network (VISN) office officials effectively monitored VISN office operations. The audit assessed VISN office management controls and fiscal operations to determine if they promoted the proper stewardship of VA funds and resources; accountability, transparency, and effective oversight of healthcare facility operations and programs; and compliance with VA regulations and policies. This audit resulted in two reports. This report discusses our assessment of management controls related to VISN office performance management, organizational structures, and staffing levels.

Mission and Origin of VISN Offices

VHA established the VISN offices to improve access to medical care and ensure the efficient provision of timely, quality care to our Nation's veterans. In 1995, VHA submitted a plan to Congress called *Vision for Change* that restructured VHA field operations into VISNs. VHA estimated that 22 VISN offices could operate annually at a cost of about $26.7 million or for approximately $9.3 million less than the cost at that time to operate 4 medical regions. VHA specifically decentralized its budgetary, planning, and decision making functions to the VISN offices in an effort to promote accountability and improve oversight of daily facility operations.

Program Magnitude

In FY 2011, VA's information systems reported that the VISN offices spent about $202.5 million for the salaries and benefits of 1,495 staff and their related expenses. Based on data in VA's automated information systems, VHA's 21 VISN offices expended about $164.9 million during FY 2010 to support their own operations. VA's Personnel and Accounting Integrated Data (PAID) system showed the VISN offices expended about $124.9 million for the salaries and benefits of 1,098 staff. VA's Financial Management System (FMS) showed the offices expended an additional $40.0 million, excluding centralized purchases on travel, rent, utilities, equipment, supplies, and services.

Recent Changes Affecting VISN Office Operations

VA establishes standards for the VA Secretary's transformation, diversity, and inclusion goals and communicates VA's performance expectations through VA's Executive Career Field (ECF) performance plans. In FY 2010, VHA's Office of Quality and Performance began addressing concerns raised by the Office of Personnel Management and an internal VHA study about the effectiveness of the ECF performance plans. As a result, VHA refined the ECF performance plan measures for the 21 VISN Directors in FY 2011. As of FY 2012, VA continues to use the ECF performance plans to assess the performance of Senior Executive Service staff including VISN Directors.

Data Reliability Issues Affecting the Audit

When viewed within the context of the audit's objective and other available evidence, the VISN office data evaluated during the audit was sufficient to reach opinions, conclusions, and recommendations related to the VISN offices' operations. Nevertheless, the absence of accurate, complete, and reliable VISN office data and widespread lack of effective management controls increased the possibility that other reportable conditions affecting VISN office staffing may have existed at the time of our audit. Finding 1 and Appendix B provide additional information on the Lack of Reliable Organizational Staffing Data and Data Reliability.

RESULTS AND RECOMMENDATIONS

Finding 1   VHA Lacked an Adequate VISN Office Performance Management System

VHA lacked an adequate performance management system to monitor, evaluate, and compare the performance of the VISN offices despite recently implemented improvements. VHA strengthened its ECF performance measures by linking VISN Director performance with the achievement of VHA organizational goals. However, VHA still lacks reasonable assurance that the "Fully Successful" performance threshold it established for VISN Directors will be sufficient to monitor and evaluate VISN Directors' performance and foster improved VISN management and oversight of healthcare facilities. Moreover, VHA did not ensure the VISN Directors implemented consistent and uniform local performance management systems at the VISN offices.

Despite VHA's recent efforts to strengthen the VISN Directors' ECF performance measures, the VISN offices' performance management system has had long-standing weaknesses because VHA has viewed them as autonomous, entrepreneurial management structures. Thus, VHA has historically not focused on the performance of the VISN Directors and their staff and ensured the uniformity of the performance management systems implemented within and across the different VISN offices. Without an adequate performance management system, VHA lacks assurance that its VISN offices are effectively managing limited VHA funds and resources and actively facilitating the achievement of VHA organizational goals at its healthcare facilities.

VISN Director Performance Management System Needs Improvement

VHA's FY 2010 ECF performance measures and performance management system did not adequately address the performance of the VISN Directors and the VISN offices. VA policy states that VA performance management systems should clearly communicate organizational goals to employees and evaluate employee performance in terms of the achievement of those organizational goals. However, the ECF performance measures and weekly and quarterly VISN performance discussions used to evaluate the VISN Directors focused on the healthcare facilities' performance instead of the VISN offices' performance. Thus, VHA focused on the performance outcomes of the healthcare facilities within the VISNs, but did not directly evaluate the VISN Directors' management of their offices and VISNs to assess how they facilitated improved performance outcomes or the achievement of VHA organizational goals at their healthcare facilities.

VHA's performance management system for its VISN Directors also raised concerns because all of its VISN Directors comfortably met the threshold for a "Fully Successful" rating and received a rating of "Excellent" or above in FY 2010. Finally, while VHA relied on ECF performance measures to evaluate its VISN Directors' performance evaluations, it did not ensure these measures uniformly and consistently flowed down to the appraisal processes of VISN office staff.

VISN Director Responsibilities and Duties Not Addressed

VHA's FY 2010 ECF system consisted of 82 separate measures covering a diverse range of operational areas. Of the 82 measures, 30 (37 percent) measures were more applicable to the performance of healthcare facility directors than VISN Directors because they addressed specific areas in clinical quality or the delivery of clinical care. Clinical care-related measures included measures such as patient satisfaction ratings and compensation and pension exam timeliness. The remaining 52 measures in the areas of general business practices, transformational core competencies, and operational core competencies applied to all VA supervisors and included specific measures such as human resource to staff ratio, equal employment opportunity compliance, and improvement of fee-basis claims processing. VHA did not refine these measures to address the specific duties, roles, and responsibilities of the VISN Directors. As a result, only 2 of the 82 measures in the FY 2010 ECF performance plans addressed management effectiveness within the VISN offices and specifically required the VISN Directors to take action and identify best practices that aligned with VHA's Strategic Objectives.

Similarly, the Deputy Under Secretary for Health for Operations and Management's (DUSHOM) and the VISN Directors' weekly and quarterly performance discussions focused primarily on the healthcare facilities' performance. Based on the VISN Directors' responses to our VISN-wide survey and discussions with the DUSHOM, they discussed topics such as the healthcare facilities' ECF performance measures, financial performance and budgetary matters, congressional concerns, major VA initiatives, local healthcare facility issues, and key leadership vacancies and recruitment during these meetings. The DUSHOM informed us that if the VISNs' healthcare facilities met the ECF measures, he assumed the VISN offices' operations were fine.

Concerns Related to the Effectiveness of the ECF Measures

The VISN Directors' ECF performance measures and implementation of those measures did not adequately foster improved VISN management and oversight of healthcare facilities. According to officials in VHA's Office of Quality and Performance and Office of Workforce Management and Consulting, the three critical elements in the VISN Directors' FY 2010 ECF performance plans constituted 60 percent of their performance ratings and

the two remaining non-critical elements constituted the remaining 40 percent. The three critical elements included measures in the areas of clinical care, business practices/acumen, and transformational core competencies. The two non-critical elements included measures related to emerging areas and operational core competencies. In FY 2010, 2 VISN Directors who retired did not receive performance ratings and the remaining 19 VISN Directors received ratings of "Outstanding" and "Excellent." The 19 VISN Directors received these ratings because their healthcare facilities comfortably exceeded the 70 percent "Fully Successful" threshold and met more than 57 of the 82 measures in the 3 critical and 2 non-critical elements of the ECF performance plans.

A review board consisting of the Under Secretary for Health, Principal Deputy Under Secretary for Health, VHA's Chief of Staff, and the DUSHOM evaluated the VISN Directors' self-assessments and a rating recommended by the DUSHOM. However, the VISN Directors' final FY 2010 ratings correlated strongly with their healthcare facilities ECF performance measure scores. Of the 19 VISN Directors who received ratings in FY 2010, 10 received "Outstanding" ratings and 9 received "Excellent" ratings. VISN Directors in regions that scored 90 percent or above on the critical elements and 80 percent or higher on the non-critical elements received ratings of "Outstanding." VISN Directors in regions that had critical element scores between 80 and 89 percent and non-critical element scores of at least 78 percent received "Excellent" ratings. VISN Directors in regions that scored in the upper 70 percent range of their critical elements but scored at least 85 percent or higher on their non-critical elements also received "Excellent" ratings.

These ratings obscure the fact that five of the VISN Directors who received "Excellent" ratings had healthcare facilities that only met 60 percent of their measures in the critical element of clinical care. The clinical care critical element addresses key areas in which VA faces continuing healthcare delivery challenges, such as compensation and pension exam timeliness, outpatient access to care wait times, and patient satisfaction. The five VISN Directors' appraisals indicated that they received these ratings because of their performance in the other critical or non-critical elements that included measures related to VHA-wide initiatives or pilot programs, the obligation of American Recovery and Reinvestment Act funds, and the timeliness of fee claims. The following examples illustrate this point.

- A VISN Director received an "Excellent" rating because of his support for pilot programs and improvement in inpatient utilization. However, the VISN's healthcare facilities missed the 30-day compensation and pension timeliness standard by 14 days, the outpatient access to care wait time benchmark of 80 by 5 points, the outpatient satisfaction benchmark of 56 by 5 points, and the inpatient satisfaction benchmark of 65 by 3 points.

- Another VISN Director received an "Excellent" rating for expanding telehealth agreements and strategically improving patient satisfaction. However, the VISN's healthcare facilities missed the 30-day compensation and pension exam timeliness standard by 15 days, the outpatient access to care wait time benchmark of 80 by 3 points, and the outpatient satisfaction benchmark of 56 by 4 points.

The proper stewardship of funds and leadership in national initiatives warrant recognition in the VISN Director performance management system. However, the weighting given these other areas in the FY 2010 appraisals can obscure the need for healthcare facilities to improve their performance relative to key clinical performance measures. As a result, the VISN Directors performance management process may not stimulate needed oversight and improvement at VISN healthcare facilities.

"Fully Successful" Threshold May Not Provide the Best Benchmark

VHA's 70 percent "Fully Successful" performance threshold for the critical and non-critical elements lacked the precision needed to be able to effectively monitor and evaluate the VISN Directors' performance even though it may provide a reasonable numerical threshold. In effect, VISNs could still fail to meet 30 percent of the ECF performance measures, and a VISN Director's performance could still be rated "Fully Successful." Therefore, the 70 percent threshold for overall performance could potentially obscure problems in the critical elements, such as clinical care, where the VISNs' healthcare facilities still need improvement. Moreover, this threshold within the current VISN Director management performance system may be too low to incentivize or stimulate improved performance if all of the VISNs comfortably meet the 70 percent threshold and all of the VISN Directors receive at least an "Excellent" rating.

Other Concerns Related to the ECF Measures

Reviews conducted by the Office of Personnel Management and a VHA workgroup raised similar concerns related to the effectiveness and usefulness of the ECF performance measures. From 2004 through 2007, the Office of Personnel Management gave VA's Senior Executive Service appraisal system a provisional certification because VA's rating system made weak distinctions between performance levels, and a significant number of performance plans either did not align with organizational goals or lacked measureable performance goals. The Office of Personnel Management

restored the certification of VA's Senior Executive Service appraisal system in July 2008. However, a March 2010 survey conducted by VHA's Performance Management Workgroup still found problems with the ECF system. Specifically, the workgroup found that the volume of performance measures diluted its effectiveness, the ECF was difficult to understand, the ECF plan did not always align with the VA Secretary's goals, and ECF ratings and rankings did not stimulate improvement.

VISN Staff Performance Management Systems Needs Improvement

VHA also did not ensure the implementation of consistent and effective performance management systems across the VISN offices. Reviews at the six VISNs visited disclosed inconsistencies in the performance standards used between offices, and in some cases, even within the same office. VISN office supervisors in different VISNs did not apply consistent performance measures to evaluate similar staff positions. Moreover, performance measures did not always link staff's performance with outcomes at the healthcare facilities, or they were difficult to apply in various cases because some VISN supervisors attempted to apply ECF performance measures without tailoring them to their staff's specific positions.

Our review of 143 FYs 2009 and 2010 performance appraisals belonging to 86 staff at 6 VISN offices disclosed inconsistencies in the use and application of ECF performances measures. We found that one VISN office used selected ECF measures to evaluate its managers and senior staff while the other five VISN offices mixed the use of selected ECF measures for some staff and the use of ECF measures tailored by position for other staff. Although the tailoring of the ECF performance measures to the staff's specific roles and responsibilities was a reasonable and prudent business practice, this practice did not occur uniformly within or across the VISN offices.

As a result, inconsistencies developed in the VISN offices' applications of the ECF performance measures. Staff in comparable positions at different offices could have significantly different performance standards because some supervisors developed standards that linked staff's performance to outcomes at the healthcare facilities while others did not, as the following example illustrates.

- One VISN office supervisor evaluated a VISN engineer mainly on personal strengths, such as being detail oriented, methodical, and factual without specifically outlining how his performance supported and affected the healthcare facilities within the VISN. In contrast, a supervisor in another VISN evaluated a VISN engineer on the construction projects he worked on at healthcare facilities and described the assistance he provided to help the facilities meet construction funding

limitations and deadlines, such as the review of project bids to ensure the projects stayed within budget and scope.

In addition, VISN supervisors could not always properly apply the ECF measures during the appraisal process because they had not tailored the measures to their staff's positions. For example, one VISN office supervisor listed clinical measures, business acumen, and transformational core competencies as critical rating elements for an Emergency Management Program Manager. However, the narrative for the program manager's "Outstanding" rating did not address his specific achievements relative to each of these critical elements, and instead, focused on his general achievements, such as how he planned a conference, contributed in committee and steering groups, and effectively responded to a natural disaster.

Recent Changes Affecting the VISN Directors ECF Performance Measures

VHA strengthened the FY 2011 ECF performance plans for VISN Directors in December 2010, but we still have some concerns related to the adequacy of the VISN Director performance management system. For FY 2011, VHA reduced the number of rating elements to two critical and two non-critical elements. Subsequently, the volume of performance measures also decreased from 82 in the FY 2010 ECF performance plans to 32 in the FY 2011 plans. Moreover, the FY 2011 plans contained 30 measures that addressed the VISN Directors' roles and responsibilities compared to only 2 measures in the FY 2010 plans. For example, a measure in the FY 2011 ECF performance plan addressed healthcare facility oversight by requiring each VISN Director to continually monitor key quality and safety indicators for inpatient and outpatient care and to assign individualized requirements as appropriate to clinical units or medical centers when specific actions or improvements were needed.

Despite the improved linkage between the VISN Directors' performance and improved outcomes at the healthcare facilities in the performance measures, the FY 2011 ECF plans continued to have some of the weaknesses that we previously noted. For FY 2010, we were concerned about the effectiveness of the 70 percent "Fully Successful" performance threshold because all of the VISNs comfortably met the threshold and all VISN Directors received an "Excellent" or above. We have similar concerns regarding the revised FY 2011 performance plans because VHA lowered the "Fully Successful" performance threshold for critical and non-critical elements to 61 percent.[1] Thus, VISN Directors only had to meet 20 of the 32 ECF performance measures to achieve at least a "Fully Successful" rating, or the equivalent of

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[1] The 61 percent "Fully Successful" threshold for the FY 2011 ECF performance measures was calculated by multiplying the number of measures that VHA required the VISN Directors to meet in each rating element by the relative weighting VHA assigned each rating element.

about 61 percent of the measures after factoring in the weighting of each element. We did not assess the impact of the 61 percent threshold on the VISN Directors' FY 2011 performance appraisals because the VA Secretary had not approved the VISN Directors' final ratings at the time we completed our audit work.

Moreover, it was not clear how VISN Directors implemented or cascaded the FY 2011 measures down to their VISN office staff's appraisals. Some measures flowed naturally down to the VISN office staff's performance. For example, one measure specifically addressed the Comprehensive Emergency Management Program and the performance of the VISN offices' emergency managers. However, the FY 2011 ECF plans did not address several other VISN office positions, such as the VISN capital asset managers, designated learning officers, and clinical informatics staff. As a result, weaknesses noted in the FY 2010 ECF plans and their implementation continued to persist in FY 2011.

Causes and Effects of an Inadequate Performance Management System

A number of factors contributed to VHA's decision not to develop and implement a comprehensive VISN performance management system. VHA believed that the VISN offices were small, autonomous management units that did not require a separate performance management system from their healthcare facilities. Thus, VHA did not develop a VISN-specific performance management system to address the VISN office staff's unique roles and responsibilities as the offices' operations grew larger and more complex.

At the same time, VHA did not monitor the management and operations of the 21 VISN offices to ensure they implemented a unified and consistent performance management system. As a result, VHA generally lacked assurance regarding the effectiveness of the VISN offices in achieving their mission. Without a performance management system tailored to measure the performance of VISN Directors and staff, VHA could not effectively evaluate how well VISN offices managed their VISNs' medical care fund allocations and actively facilitated the achievement of VHA organizational goals at their healthcare facilities.

Conclusion

VHA recently strengthened the performance measures used to evaluate VISN Directors to more effectively communicate and clarify organizational goals and to link individual appraisals and performance to the achievement of these organizational goals. However, VHA needs to monitor the effectiveness of the threshold it has established for the "Fully Successful" performance level of its VISN Directors. Although VISN Directors may hold challenging positions, VHA must ensure that the VISN Directors' performance management system allows for the continuous identification of problem areas and that it promotes improved performance. In addition, VHA needs to ensure the consistent and uniform implementation of the VISN Directors'

performance measures as they cascade down to the evaluation of their offices' staff. At this time, VHA lacks assurance that different VISN offices, and even supervisors within the same VISN office, consistently and uniformly apply ECF and/or other measures derived from the ECF performance plans to conduct performance appraisals.

Recommendations 1. We recommended the Under Secretary for Health review FY 2012 Veterans Integrated Service Network Director performance appraisals and appraisal input to ensure that the revised performance measures and "Fully Successful" performance threshold facilitate the identification of problem areas and improved performance outcomes.

2. We recommended the Under Secretary for Health implement a control mechanism to ensure the uniform and consistent implementation of performance measures across and within Veterans Integrated Service Network offices and the linkage of the performance measures with the achievement of VHA organizational goals.

Management Comments The Under Secretary for Health agreed with our findings and recommendations, and plans to address our recommendations by November 30, 2012. The DUSHOM conducts quarterly reviews of VISN performance to address performance metrics and opportunities for improvement in VISN Director Performance Plans. The DUSHOM will perform an overall assessment of the evaluation process at the end of the rating period to ensure the effectiveness of the performance measures and use of the "Fully Successful" performance threshold. For FY 2012, the VISN Director's performance plans have been cascaded down to VISN staff with performance metrics for positions to allow the evaluation of individual and organizational performance at every level of the organization. Uniform implementation of this structure will be reinforced during weekly calls, quarterly reviews, and by holding senior executives accountable to Office of Personnel Management defined leadership metrics

OIG Response The Under Secretary provided a responsive action plan to address our recommendations. We will monitor the Department's progress and follow up on its implementation until all proposed actions are completed. Appendix C provides the full text of the Under Secretary's comments.

Finding 2   VHA Needs To Strengthen Oversight of Organizational Structures and Staffing Levels of VISN Offices

VHA had not established adequate controls over the VISN offices' organizational structures and staffing levels to ensure transparency and the effective and efficient use of funds and resources. VA human resource policy required managers to establish minimum staffing levels and review processes to ensure that they achieved their missions with the minimum number of staff.[2] Nevertheless, VHA did not adequately oversee the development of the 21 VISN's organizational structures and staffing levels as they evolved over 16 years and grew larger and more complex. Thus, VISN Directors had the broad authority and discretion to add positions below the General Schedule 15 level and determine the mix and composition of their offices' staff without any systematic monitoring and review and approval process.

This led to a lack of standardization in VISN offices and meant that VHA could not ensure the VISN offices' staffing levels and configurations provided the most effective and efficient use of funds and resources to achieve their mission. Specifically, VHA lacks assurance that the VISN offices have used the minimum number of staff necessary to accomplish mandated functions, properly assigned clinical staff to VISN office positions, and only used the minimum number of administrative staff needed to support their offices.

Lack of Reliable Organizational Staffing Data

VHA lacked accurate and reliable VISN office staffing data with which to assess the offices' organizational structures and staffing levels. VA policy requires VA managers to establish a minimum number of positions, conduct systematic examinations, and develop action plans to accomplish the mission utilizing the most effective work processes, procedures, methods, and techniques. In addition, VA managers are required to assess their staffing levels and ensure they accomplish their mission with the minimum number of staff. Nevertheless, VHA lacked an audit trail documenting the staffing and structural changes that have occurred in the VISN offices over time because VHA has not historically monitored the VISN offices' operations.

Our data reliability testing disclosed that the VISN office data contained in automated systems such as FMS and PAID were inaccurate, incomplete, and unreliable. Inconsistencies and inaccuracies in VISN office administrative and fiscal data limited the extent to which we could review and analyze the data. For example, VISN offices commingled all of their staffing and related expenditure data with that of the healthcare facilities in their regions prior to

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[2] VA Directive 5003, *Position Classification, Job Grading, and Position Management*, dated April 15, 2002.

FY 2010. As a result, the PAID system, VA's automated payroll system, which normally has historical staffing and salary data for all VA facilities, lacked data for the VISN offices prior to FY 2010. Furthermore, although VHA's Office of Finance established VISN office station numbers and control points in FY 2010, the DUSHOM's office still lacked reliable VISN office organizational and staffing information at the start of our audit.

Comparisons of VISN office FY 2010 PAID staffing data with staffing data reported to the VA Secretary in FY 2009[3] disclosed significant discrepancies. Data reported to the VA Secretary showed the VISN offices had about 4,565 full-time equivalent employees (FTE) in FY 2009, including staff in centralized positions.[4] Moreover, a comparison of the staffing data reported to the VA Secretary (about 4,565 FTE) and FY 2010 PAID data (1,098 FTE) revealed a discrepancy of about 3,467 FTE. We attributed the discrepancies in the VISN office staffing data to inconsistencies in the data the VISNs reported to the Secretary and in the PAID system.

Although VHA's Office of Finance assigned the VISN offices separate fund control points in FY 2010 to monitor their obligations and expenses, VHA did not provide VISN offices specific instructions on which staff and expenses should be accounted for under their fund control points. Subsequently, when the VISN offices reported their FY 2010 staffing data in PAID and to the Office of Inspector General (OIG) during the audit, many offices still appeared to rely on guidance issued by the former DUSHOM in 2006 that defined the VISN office as a specific group of 18 occupations and their support staff.

As a result, the VISN offices tended to not report their virtual and centralized staff to the OIG and in the PAID system even though the VISN offices managed these staff and included them in the FY 2009 staffing data reported to the Secretary. Due to the inconsistencies in the VISN offices' reporting, we could not be sure that their reported FY 2010 staffing data included all of their staff.

Based on our work, we concluded the reporting and accounting discrepancies in the number of VISN office staff resulted from the offices' confusion regarding who they should count as a VISN office employee. An official in the DUSHOM's office suggested that the VISN offices might be confused about how to account for "hoteling" staff the VISN offices house and pay for while the staff are detailed to support selected VHA healthcare initiatives. However, information provided by the VISN offices indicated that they

[3]In FY 2009, the 21 VISN Directors provided VISN office staffing information along with other VISN-wide information such as geography, governance, and challenges to the then newly appointed VA Secretary.
[4] Centralized staff are staff who support the VISNs' healthcare facilities, but whose positions and functions have been consolidated under the VISN offices' operations.

maintained very few "hoteled" staff. The majority of the staff who supported VHA programs or initiatives at the VISN offices functioned as VISN staff who were paid and managed by local VISN officials.

The absence of reliable and accurate data related to the size, composition, and salary costs of the 21 VISN offices prevents transparency in the VISN offices' operations. Moreover, VA and VHA officials lack key organizational and staffing information needed to effectively oversee the VISN offices and evaluate the effectiveness of their operations.

Unmonitored Growth in VISN Organizational Structures and Staffing

VHA has not managed and monitored the growth of the VISN offices. According to VHA's 1995 restructuring plan titled *Vision for Change*, the total staffing for the VISN offices should have ranged between 154–220 FTE with the size of the offices based on the size and complexity of the healthcare facilities within their regions. Instead, the staffing data reported to the VA Secretary in FY 2009 indicates that the VISN offices' current staffing may be closer to about 1,054 FTE (excluding centralized positions), about a 380 percent increase above the maximum number of staff originally planned for in the *Vision for Change*.

Moreover, from the staffing data we could validate, we found that VISN office staffing levels varied greatly regardless of the number of patients served by the VISNs' facilities and the number and complexity of the healthcare facilities. VHA's Office of Quality and Safety assigns healthcare facilities complexity levels based on the characteristics of a healthcare facility's patient population, the clinical services it offers (cardiac surgery is considered more complex than throat surgery), educational and research missions, and its administrative complexities. The following example illustrates the variability in VISN office staffing levels.

- A VISN office used 66 FTE to oversee about 310,000 patients at 8 healthcare facilities with generally low complexity levels. In contrast, another VISN office that oversaw healthcare facilities of generally the same complexity level used 131 FTE or 65 more FTE to oversee the same number of facilities but about 70,000 fewer patients.

In addition, VISN offices with larger staff did not necessarily perform significantly better than VISN offices with fewer staff when we examined the FY 2010 ECF performance measures used to evaluate VISN performance. For example, a comparison of two VISNs of comparable size and complexity showed that both met 82 percent of their ECF critical performance measurements, but one VISN office had 81 FTE while the other had 61 FTE.

According to the DUSHOM's office, the significant growth in the VISNs' organizational structures and staffing may be attributable to the increasingly

complex national VHA healthcare system that has developed to serve the veteran population's increasingly diverse healthcare needs. Since the inception of the VISNs, the veteran population has increased. VHA has also expanded programs and services in areas such as, non-institutional care, women's health, palliative care, and rural health. Further, VHA has increased the number of community based outpatient clinics, nursing homes, and Vet Centers serving veterans throughout the country. Nevertheless, VHA's lack of oversight and the autonomy it has given the VISN Directors over the VISN offices' operations has made the VISN offices more susceptible to possible inefficiencies in their organizational structures and staffing.

Inadequate Monitoring of the Use of Clinical Staff

VHA has not ensured the effective use of clinical staff assigned positions at the VISN offices. Although some VISN office positions require staff with clinical experience, 18 (86 percent) of the 21 VISN offices did not properly monitor the use of clinical staff to fill VISN office positions. Of the 251 Title 38[5] clinical staff employed by the VISN offices, at least 37 (15 percent) held positions that did not require clinical skills and should have been filled by Title 5 administrative staff. VA Handbook 5005, Part III, Appendix N, requires responsible officials to assign Title 38 staff duties that require clinical skills, prohibits use of Title 38 staff for competitive civil service positions, and requires the assignment of Title 5 employees to administrative positions that do not require clinical skills because the roles and responsibilities are administrative in nature.

Despite these requirements, the VISN offices filled administrative positions, such as the My HealtheVet coordinator and patient safety officer, with Title 38 clinical staff whose salaries totaled about $4.2 million even though the use of Title 5 staff would have generally been more cost effective. For example, one VISN office employed a Title 38 nurse with an annual salary of about $123,000 as a My HealtheVet coordinator, even though VA's HR office had classified this job in this geographical area as a Title 5, GS-12 position, with an annual salary of $75,222. Further, the hiring of a Title 38 nurse for this position did not appear to enhance the implementation of the My HealtheVet Initiative. Both the Title 38 and Title 5 My HealtheVet VISN coordinators successfully implemented the initiative and ensured their healthcare facilities had staff to train veterans on how to access their personal health records on the My HealtheVet Web portal.

VISN office supervisors and human resource staff generally indicated they were not aware that VA policy prohibited the use of Title 38 staff for administrative Title 5 positions. In addition, VA Central Office Professional

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[5] Title 38 staff positions include 12 clinical occupations, such as physicians, dentists, and registered nurses.

Standards Board officials, responsible for reviewing the appointments and awards of executive clinical staff, stated that they had not been monitoring the VISN offices assignments of Title 38 positions closely, but would do so in the future.

Inadequate Monitoring of Administrative Support Staff

VHA has not determined the appropriate ratio of supervisory to non-supervisory positions as required by VA human resource policy to prevent the overuse of administrative support staff at the VISN offices. VA policy requires management to determine the appropriate ratio of supervisory positions to those of non-supervisory positions to prevent excessive and unwarranted use of administrative support staff.[6] Based on staffing data the VISN offices reported to the OIG during the audit, administrative support staff[7] for the 21 VISN offices ranged from a low of 4 FTE at an annual cost of about $338,000 to a high of 32 FTE at an annual cost of $2 million.

In FY 2010, VISN offices spent about $16.4 million on 259 administrative support staff, or about 13 percent of the VISN offices' reported salaries (excluding the salaries of centralized staff). Further, the number of administrative support at each VISN office varied independently from the VISN office's staffing levels and the VISN healthcare facilities' complexity and size.

For example, one VISN office had 19 administrative staff to support 131 VISN office FTE while another VISN office used 6 administrative staff to support 117 VISN office FTE. The VISN office with less administrative staff also oversaw 2 additional healthcare facilities with about 114,000 more patients and healthcare facilities of a generally higher complexity level than the VISN office with the higher number of administrative support staff. The VISN Director with 19 administrative staff believed that the high level of administrative support was justified because VHA's central office had similar positions and executive and clinical program managers needed the additional support.

Inadequate Monitoring of VISN Program and Initiative Staffing

VHA lacks assurance that VISN staff added to perform VHA oversight functions for programs and initiatives represent an effective and efficient use of funds. Various VHA program offices mandate oversight for programs and initiatives that require the assignment of program managers, coordinators, or liaisons at the VISN offices. The VISN staff coordinate the implementation of the programs and initiatives at the VISNs' healthcare facilities by providing program guidance, performing monitoring and reporting functions,

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[6] VA Directive 5003, *Position Classification, Job Grading, and Position Management*, dated April 15, 2002.

[7] Administrative support staff at the VISN offices spent the majority of their time performing duties such as clerical work, the review and approval of travel, the preparation and submission of data requests, scheduling of meetings and preparation of meeting minutes, internship work, and/or monitoring tracking sheets for program managers.

and facilitating communication between the program offices and the healthcare facilities. In some cases, VHA provides the VISN offices with the staff and funding for the oversight functions. In other cases, the VHA program offices prescribe the minimum oversight standards and expect the VISN offices to allocate the resources needed to meet the standards. A number of VISN Directors indicated their offices' staffing levels were largely determined by the oversight activities mandated by VHA.

Our audit identified significant variations in the staffing and resources VISN offices used to oversee selected programs and initiatives. In addition, we found that higher VISN office staffing allocations dedicated to the oversight of initiatives and programs did not necessarily result in measurable improvements in the program outcomes at the healthcare facilities. Equally important, VHA lacked the management controls needed to assess whether the assignment of additional resources at the VISN offices resulted in improved outcomes, services, or communication. Discussion of the special initiatives and programs reviewed at the VISN offices follows.

My HealtheVet Initiative

The DUSHOM's office mandated and funded a My HealtheVet point of contact (POC) for each VISN office to perform liaison and coordination responsibilities for the program office and healthcare facilities. Nevertheless, 14 (67 percent) of the 21 VISN offices assigned the My HealtheVet POC as a collateral duty to existing staff. Offices that made this position a collateral assignment used the funding for other purposes. At the six offices visited, five had assigned the My HealtheVet responsibilities as a collateral duty and only one had assigned an FTE to these responsibilities. Despite the differences in the assigned VISN office resources, all six met the program's performance goals. In this case, VHA did not effectively monitor the My HealtheVet initiative funding and resources at the VISN offices to ensure the FTE and additional funding were needed.

Operation Enduring Freedom/ Operation Iraqi Freedom Program

VHA's Care Management and Social Work office requested each VISN office assign an Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) program VISN POC. The program office intended the OEF/OIF program VISN POC to serve as a liaison between the program office and healthcare facilities, report on national goals, and promote the use of standardized procedures. Eleven offices assigned OEF/OIF program VISN POC duties as collateral responsibilities to existing staff, nine VISN offices hired full-time staff, and one created an entire service line including administrative support. The OEF/OIF program had general performance goals for the healthcare facilities' OEF/OIF case managers' performance but lacked specific performance measures for the VISN POCs. Consequently, VHA lacked an effective system with which to evaluate the VISN POCs' performance and to ensure the assignment of the optimal level of VISN POC

staff to help healthcare facilities achieve their OEF/OIF program performance goals.

When it came to meeting the OEF/OIF program performance goals, the VISN office that had assigned an entire service line to the VISN POC function met both of the program's performance goals, but so did other VISN offices that had assigned the function as a collateral duty. Regardless of the number of staff assigned at the VISN offices, the majority of the healthcare facilities met only one of the program's two performance goals. Most met the goal to maintain ongoing communication with OEF/OIF veterans. However, most did not meet the goal that required case managers at healthcare facilities to follow up with veterans within seven days after initial contact.

Women Veterans Program

VHA's Women Veterans Health Strategic Health Care Group required all VISN offices to assign a Lead Women Veterans Program Manager to promote quality improvement, serve as a liaison between the program office and healthcare facilities, and report on women veterans' national targets. Twelve VISN offices assigned the Lead Women Veterans Program Manager responsibilities as collateral duties to existing staff, seven VISN offices hired full-time staff, and two VISN offices established a full service line. Nevertheless, the number of FTE the VISN office assigned to the program did not affect the healthcare facilities' ability to achieve the program's goals. For example, one VISN, where the VISN office assigned the liaison responsibilities as a collateral duty, successfully met four of the primary Women Veterans program's goals. However, another VISN with a comparably sized population of women veterans, where the VISN office assigned three FTEs (one liaison manager and two outreach staff), only met one of the program's four goals.

Program officials responsible for My HealtheVet, the OEF/OIF program, and the Women Veterans Health program generally acknowledged that the various organizational structures and staffing at the VISN offices did not necessarily improve quality and performance at the VISNs' healthcare facilities. In response to our audit results and the lack of management controls over staffing, the DUSHOM acknowledged this area required attention. The DUSHOM stated his office planned to improve communication and coordination with the various VHA program offices to establish expectations and performance measures for VHA mandated positions at the VISN offices.

Causes and Effects of Inadequate Organizational Structure and Staffing Controls

VHA conceived the VISN offices as entrepreneurial and innovative managerial units that needed flexibility to handle the varying needs of their healthcare facilities. Thus, VHA vested its VISN Directors with broad authority to shape their organizational structures and staffing levels as they deemed necessary. This concept of operations led to a lack of standardization in the organizational structure and staffing levels. Moreover, in implementing its VISN management model, VHA did not establish needed checks and balances on the VISN offices' organizational structures and staffing levels to ensure the efficient use of medical care funds and resources and the effectiveness of operations.

The lack of accurate information regarding the VISN offices' organizational structures and staffing levels prevented transparency in the VISN offices' operations. Moreover, without adequate management controls such as staffing guidelines and monitoring processes, VHA could not ensure VISN office staffing increases resulted in improved oversight and measurable program improvements at healthcare facilities. Thus, VHA generally lacked assurance that the VISN offices' organizational structures effectively and efficiently performed needed management and oversight responsibilities using the minimum number of staff. Moreover, the wide variations in the VISN offices' organizational structures and use of staff to meet program requirements also demonstrated the lack of a clear, consistent, and well-defined VISN office mission.

Conclusion

VHA lacked fundamental management controls and quality data needed to ensure that VISN offices effectively and efficiently use staffing resources that might otherwise be used for direct patient care. Moreover, the VISN offices need a clearly defined mission to guide their operations before VHA can properly measure and evaluate the VISN offices' performance and operations. In response to our results, the DUSHOM stated that the current process for establishing VISN office staffing was not as effective as it could be and that an analysis should be completed to reevaluate positions. Further, the DUSHOM established a number of work teams to analyze the VISN offices' operations and to address the VISN offices' lack of "a clear, consistent definition of purpose that links to a standard structure and functional capability."

Recommendations
3. We recommended the Under Secretary for Health develop a clear definition of who is a Veterans Integrated Service Network office employee; ensure Veterans Integrated Service Network offices consistently apply this definition; and maintain accurate, reliable, and complete Veteran Integrated Service Network office staffing data in VA's automated information systems and other appropriate management information systems.

4. We recommended the Under Secretary for Health develop management controls, including staffing guidelines and review and approval processes for new Veterans Integrated Service Network office positions, to ensure Veterans Integrated Service Network offices' organizational structures and staffing reflect the optimal use of funds to achieve the offices' mission.

5. We recommended the Under Secretary for Health review current Veterans Integrated Service Network office positions filled by Title 38 staff to ensure that the positions require clinical knowledge and skills, and if not, require Veterans Integrated Service Network Directors to take action at the earliest feasible point possible to reclassify the positions as administrative positions.

6. We recommended the Under Secretary for Health establish the appropriate ratio of supervisory to non-supervisory positions for the Veteran Integrated Service Network offices as required by VA policy and ensure the Veterans Integrated Service Network offices move toward compliance with these guidelines at the earliest feasible point possible.

Management Comments   The Under Secretary for Health agreed with our findings and recommendations, and plans to address our recommendations by March 30, 2013. VHA will develop guidance to account for VISN office and centralized facility support unit staff. The DUSHOM will monitor VISN office staffing against operating plans and compare it with data from VA automated information systems to ensure the data's reliability and accuracy. Moreover, VHA will develop a staffing and management control structure for VISN offices. VHA is taking action to review and approve VISN office staff, develop a basic VISN office framework, and define base staffing levels, core staff, and functions. VHA will also develop staffing guidelines and review processes for new positions; review, and where needed, adjust Title 38 positions; and develop a ratio of supervisory to non-supervisory staff and implement changes where required.

OIG Response   The Under Secretary provided a responsive action plan to address our recommendations. We will monitor the Department's progress and follow up on its implementation until all proposed actions are completed. Appendix C provides the full text of the Under Secretary's comments.

Appendix A Background

Mission and Origin of VISNs

In 1995, VHA submitted a plan to Congress called *Vision for Change* that restructured VHA field operations from 4 medical regions to 22 VISNs (currently 21 VISNs). VHA initiated the reorganization to:

- Redistribute VHA healthcare resources to better meet veterans' needs.

- Encourage innovative approaches to improve veterans' access to VHA health care.

- Decentralize decision-making and operations.

According to the *Vision for Change*, the size and complexity of the individual VISNs would determine the VISN offices' staffing allocations. During the initial reorganization that formed the VISNs, VHA expected the VISN offices' staffing needs to range between 7 to 10 FTE and staffing to be the offices' largest recurring cost. VHA estimated that VISN management structure costs would be about $26.7 million or $9.3 million less than the cost associated with the four medical regions in existence at that time.

Program Office Responsibilities and VISN Background Information

Currently, VHA's DUSHOM's office oversees the VISN offices and provides the VISN Directors broad and general operational direction and guidance. In addition to budget and planning responsibilities, VISN offices provide guidance and oversight to healthcare facilities and advice to the DUSHOM's office in the following program areas:

- The system-wide ongoing assessment and review strategy

- Clinical quality management

- Capital asset management

- Safety and health

- Environmental and engineering programs

Moreover, the role of the VISN offices has evolved significantly due to the centralization and consolidation of service lines and the increased oversight needed for clinical and administrative areas for the 152 VHA healthcare facilities and over 1,220 related community based outpatient clinics, nursing homes, and Vet Centers throughout the country.

Table 1 provides VISN background information related to VISN office staffing and the region's healthcare operations. The FY 2010 data is the number of unique employees the VISN offices reported in the PAID system. The FY 2009 data is the (rounded) number of FTE the VISNs reported to the VA Secretary.

Table 1: VISN Background Information					
VISN Office	**Healthcare Facilities**	**VISN-wide Complexity**	**Unique Patients Served**	**FY 2010 PAID Staff Data**	**FY 2009 Reported FTE**
01: Bedford, MA	8	Low	246,432	30	574
02: Albany, NY	5	Low	138,028	20	401
03: Bronx, NY	8	Medium	183,332	44	125
04: Pittsburgh, PA	10	Low	314,881	66	49
05: Linthicum, MD	4	High	143,035	56	66
06: Durham, NC	8	Low	314,403	50	381
07: Duluth, GA	10	Medium	360,672	45	440
08: Bay Pines, FL	7	High	543,991	95	262
09: Nashville, TN	7	High	286,688	60	661
10: Cincinnati, OH	5	Medium	215,898	48	63
11: Ann Arbor, MI	8	Low	263,085	60	150
12: Hines, IL	7	High	256,392	41	36
15: Kansas City, MO	9	Medium	240,675	40	141
16: Ridgeland, MS	11	Medium	482,348	55	172
17: Arlington, TX	5	High	278,269	139	141
18: Mesa, AZ	6	Medium	260,771	51	127
19: Glendale, CO	6	Low	179,188	36	165
20: Vancouver, WA	7	Medium	255,066	51	231
21: Mare Island, CA	7	Medium	270,331	29	39
22: Long Beach, CA	5	High	292,614	43	291
23: Minneapolis, MN	9	Low	307,501	39	51
Totals	**152**		**5,833,600**	**1,098**	**4,566**

Sources: VHA and VA

Other VA and VHA Program Offices

VA's Office of Finance is responsible for improving the quality of the Department's financial services and maintaining FMS (VA's core accounting system), PAID (VA's payroll and human resource systems), and related applications. VHA's Chief Financial Officer oversees VHA's Office of Finance and provides fiscal guidance and policies to VISN Directors. However, the VHA Chief Financial Officer has no direct line authority over the VISNs.

The Office of Quality and Performance develops and maintains VHA's extensive system of clinical performance measures, including patient satisfaction surveys. The Office of Quality and Performance, the National Advisory Counsel for Clinical Practice Guidelines, and various VHA administrators and clinicians form VHA's Performance Measurement Workgroup. The workgroup develops and identifies clinical and operational performance measures for VHA's ECF performance plans.

The Office of Workforce Management and Consulting provides guidance and recommendations for VHA workforce management functions, which includes areas related to the ECF performance management system. The office provides guidance on the ECF management system, which governs the VISN Directors and most of the VISN office staff's performance appraisals and ratings.

Management Information Systems

PAID is a VA-wide automated records system that encompasses personnel, payroll, and related fiscal operations. It incorporates a payroll accounting and general ledger system that interfaces with VA's central accounting system, FMS. The PAID system also provides VA with an automated time and attendance system and allows it to maintain mandatory and optional data for all VA employees, such as information on employment status, payroll earnings for the tax year, and annual and sick leave balances. Automated reports from PAID provide information on payroll, time and leave units, tours of duty, timekeeping and supervisory certification, and overtime management. More specifically, PAID can generate reports for staffing, salary, and performance awards by station number.

FMS is a standardized, integrated, VA-wide system that supports the collection, processing, and dissemination of several billion dollars of financial information and transactions each FY. On October 1, 2009, VHA required VISN offices to establish unique station numbers and fund control points (FMS accounts used to manage fund distributions and obligations) so that expenditures, such as salary costs, could be monitored.

Appendix B   Scope and Methodology

Audit Scope

We conducted our audit work from November 2010 through December 2011. Our audit primarily reviewed FY 2010 data for the 21 VISN offices including FMS fiscal data, PAID salary data, and detailed staffing information. Because of changes VHA made in the VISN Directors' FY 2011 ECF Performance Plans during the audit, we also selectively reviewed ECF performance plan information for FY 2011.

We could only review selected FY 2009 records, such as FY 2009 staffing reports submitted to the VA Secretary by the VISN offices, because the VISN offices lacked auditable fiscal and personnel data prior to FY 2010. Until FY 2010, the VISN offices lacked the station numbers and fund control points with which to track VISN staff and their related expenses. As a result, the OIG had to obtain staffing levels and information about the VISN offices' organizational structures directly from the offices at the start of the audit.

Further, we selected a sample of six VISN offices to review based on variations in their reported expenditures, staffing levels, overall VISN-wide healthcare facility complexity levels and size (unique patients served and number of healthcare facilities). During our site visits, we identified the number of administrative support staff at the VISN offices. We categorized VISN staff as administrative support staff if the employee spent the majority of his or her time performing duties such as clerical work, the review and approval of travel, the preparation and submission of data requests, scheduling of meetings and preparation of meeting minutes, internship work, and/or monitoring tracking sheets for program managers.

We also assigned VISN-wide complexity levels of High, Medium, or Low based on the average complexity levels of the healthcare facilities within their VISNs. The table below shows the six VISN offices we selected and visited, the expenditure and staffing level data they initially reported to the OIG, and other information, such as VISN size, used for site selection. The staffing and expenditure data presented in the table may differ from data in other sections of the report because the VISNs reported this information in response to our requests at the start of the audit.

Table 2. VISN Office Site Selection Information					
VISN Office	Healthcare Facilities	VISN-Wide Complexity Levels	Unique Patients Served	Staffing Levels	FY 2010 Operating Budget
01: Bedford, MA	8	Low	246,432	30	$3,840,000
06: Durham, NC	8	Low	314,403	78	10,809,688
08: Bay Pines, FL	7	High	543,991	110	10,766,825
16: Ridgeland, MS	10	Medium	482,348	67	8,510,244
17: Arlington, TX	5	High	278,269	93	8,325,000
22: Long Beach, CA	5	High	292,614	52	5,955,666

Source: VHA

For the sites visited, we evaluated VHA and VISN office management controls and procedures used to oversee operations. In addition, we analyzed reported VISN office staffing data and reviewed the annual performance and special contribution award documentation of staff who received cumulative annual awards of $7,500 or more.

Methodology   We interviewed VA, VHA, and VISN office officials to gain an understanding of the controls used to monitor and oversee the VISN offices. We performed a comparative analysis of the VISN offices to determine whether VISN offices with similar patient workloads and complexity levels had significantly different operational budgets, and within this context, how VHA assessed the effectiveness of the VISN offices' performance and operations. We administered a web-based survey to 21 VISN Directors. We reviewed documentation and interviewed staff for selected financial transactions, leases, and awards to assess appropriateness and compliance with applicable VA policies and Federal regulations.

Fraud Detection   Given the audit's objective, we assessed the risk of fraud as low. However, we included audit steps to identify potential fraudulent activities. We developed specific audit steps to determine what management controls, if any, were in place to identify potentially fraudulent VISN office transactions. Further, we continually reviewed and assessed selected financial transactions for appropriateness, such as travel expenditures and high dollar value transactions. We identified a small number of transactions with a higher risk for fraud and referred these transactions and related information to the OIG's Office of Investigations for further evaluation.

Data Reliability   To achieve the audit's objective, we independently verified, validated, and assessed the reliability of VISN office data provided to the OIG and reported in VA automated information systems.

We obtained computer-processed data from FMS and PAID for FY 2010. For each VA system we used in our work, we (1) obtained information from the system owner or manager on its data reliability procedures, (2) reviewed systems documentation, and (3) performed electronic testing of the databases to identify obvious errors in accuracy and completeness.

To test the reliability of FMS computer-processed data, we compared data to invoices and verified key fields such as purchase date, invoice total amount, vendor, and budget object code. We also performed extensive testing to verify expenditure totals for 21 VISN offices and when we found obvious discrepancies, such as centralized purchases for equipment, we confirmed discrepancies with VISN office financial staff and made appropriate adjustments to transaction data used in our analysis.

In addition, to test the reliability of PAID computer-processed staffing data, we compared the data with staffing information VISN management provided to the OIG in FY 2010 and information provided to the VA Secretary in FY 2009. We also interviewed VISN office staff, such as the Chief Financial Officers, budget analysts, and human resource managers to discuss data reliability at the six VISN offices visited.

Our testing disclosed that the VISN office data contained in automated systems such as FMS and PAID were inaccurate, incomplete and unreliable. Inconsistencies and inaccuracies in VISN office administrative and fiscal data limited the extent to which we could review and analyze the data. However, this data, when viewed within the context of the audit's objective and other available evidence, was sufficient to reach the opinions, conclusions, and recommendations made in this report.

Government Audit Standards   Our assessment of internal controls focused on those controls related to our audit's objective. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. However, the absence of accurate, complete, and reliable VISN office data, (discussed previously) and the widespread lack of effective management controls significantly increased our audit risk. Therefore, we cannot provide reasonable assurance as to the completeness of our findings.

Appendix C   Under Secretary for Health Comments

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Department of Veterans Affairs

Memorandum

Date: March 21, 2012

From: Under Secretary for Health (10)

Subj: Office of Inspector General, Office of Audits and Evaluations Draft Report, Audit of VISN Management Control Structures (VAIQ 7205821)

To: Assistant Inspector General for Audits and Evaluations (52)

1. I have reviewed the draft report and concur with all six of the report's recommendations. Attached is the Veterans Health Administration's (VHA) corrective action plan for the report's recommendations.

2. During the Office of Inspector General (OIG) review and prior to the receipt of the OIG's draft report, VHA undertook an aggressive management review of Veterans Integrated Service Network (VISN) staffing levels. A senior workgroup reviewed each VISN's organization structure, staffing definitions, staffing levels and related issues and subsequently developed recommendations to improve the alignment of staffing levels to core VISN functions. VHA is committed to completing this management review and fully implementing the recommendations no later than Fiscal Year 2013. The goals are to improve accountability, transparency, and standardization of VISNs as they provide Veterans and their families with high quality health care, good customer service, and maximum efficiency.

3. Thank you for the opportunity to review the draft report. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.

Robert A. Petzel, M.D.

Attachment

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VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, OIG Draft Report, Audit of VISN Management Control Structures (VAIQ 7205821)

Date of Draft Report: February 17, 2012

Recommendations/ Actions	Status	Completion Date

Recommendation 1: We recommend the Under Secretary for Health review FY 2012 Veterans Integrated Service Network Director performance appraisals and appraisal input to ensure that the revised performance measures and "Fully Successful" performance threshold facilitate the identification of problem areas and improved performance outcomes.

VHA Comments

Concur

VHA's Deputy Under Secretary for Health for Operations and Management (DUSHOM) conducts quarterly reviews with the Veterans Integrated Service Network (VISN) Directors to address performance measures and opportunities for performance improvement in the areas identified in the VISN Director's Performance Plans. The reviews focus on organizational priorities, as well as VISN specific metrics, to include overall efficiency and population health metrics. The DUSHOM will perform an overall assessment of the VISN Director's fiscal year (FY) 2012 performance appraisal process at the end of the rating period to evaluate the effectiveness of the performance measures and the fully successful threshold in ensuring the identification of problems and improved performance outcomes at the VISNs.

	Status	Completion Date
	In process	Next round of quarterly reviews to begin July 1, 2012
	In process	Summary review November 30, 2012

Recommendation 2: We recommend the Under Secretary for Health implement a control mechanism to ensure the uniform and consistent implementation of performance measures across and within Veterans Integrated Service Network offices and the linkage of the performance measures with the achievement of VHA organizational goals.

VHA Comments

Concur

In FY 2012, the VISN Director's performance plans were written to link the VISN Director's plan to the Department of Veterans Affairs (VA) Transformational Initiatives. The plans also include five critical elements derived from the new Government-Wide Senior Executive Service (SES) Performance Management System:

- Element 1 Leading Change
- Element 2 Leading People
- Element 3 Business Acumen
- Element 4 Building Coalitions
- Element 5 Results Driven

This revised plan is cascaded down to employees in each organization and includes specific performance metrics for positions. This approach provides a structure for the organization to evaluate individual and organizational performance at every level of the organization. Definitions for each performance metric have been defined in a technical manual or within each performance plan. To ensure uniform implementation, VISN Director Calls are held weekly to focus on key administrative, and clinical performance areas; the quarterly VISN reviews will be aligned with a uniformed review of transformation initiatives (including spend plans and performance), and all senior executives will be held accountable for Office of Personnel Management defined leadership metrics.

                                     In process   May 31, 2012

Recommendation 3: We recommend the Under Secretary for Health develop a clear definition of who is a Veterans Integrated Service Network office employee; ensure Veterans Integrated Service Network offices consistently apply this definition; and maintain accurate, reliable, and complete Veteran Integrated Service Network office staffing data in VA's automated information systems and other appropriate management information systems.

VHA Comments

Concur

VHA will implement a process to review all staff members for all VISNs. This process will then define core VISN staff for each VISN based on the functional definition of the VISN. This core staff definition will define the functions of the staff. The definition will also set the base staffing levels for VISNs. VHA will initiate reviews of VISN full time equivalent and VISN personnel and related costs. VHA's Office of Finance will develop policy to provide guidance on accounting for VISN staff and centralized facility support units. Execution will be monitored against approved VISN Office and VISN Operating Plans and compared with data

reported in the Financial Management System and the Personnel and Accounting Integrated Data System to ensure accuracy and reliability during monthly reports to the DUSHOM.

In process	Functional Definition established by June 30, 2012
	Quarterly reviews using automated tools begin December 31, 2012

Recommendation 4: **We recommend the Under Secretary for Health develop management controls, including staffing guidelines and review and approval processes for new Veterans Integrated Service Network office positions, to ensure Veterans Integrated Service Network offices' organizational structures and staffing reflect the optimal use of funds to achieve the offices' mission.**

VHA Comments

Concur

VHA will develop an organization structure that identifies the basic framework for a VISN Office. Each VISN will then ensure that its organization conforms to the organization structure. To further ensure effective oversight of VISN organizational structures, any variances from the approved VISN staffing guidelines will require review and approval by the DUSHOM Resource Management Board to ensure efficient and effective VISN staffing resource allocations. VISNs will submit quarterly reports to the DUSHOM showing VISN Office staffing compared to overall approved staffing ceilings.

In process	Framework to be developed by June 30, 2012

Recommendation 5: **We recommend the Under Secretary for Health review current Veterans Integrated Service Network office positions filled by Title 38 staff to ensure that the positions require clinical knowledge and skills, and if not, require Veterans Integrated Service Network Directors to take action at the earliest feasible point possible to reclassify the positions as administrative positions.**

VHA Comments

Concur

VHA will develop a standard organization structure that identifies Title 38 staff. VHA will review VISN positions to assess the appropriate use of Title 38 staff within VISN Office positions. The DUSHOM will develop an action plan with timelines and milestones for VISNs to adjust if inappropriate use of Title 38 staff is identified.

In process	Action plans to be developed by September 30, 2012

Recommendation 6: **We recommend the Under Secretary for Health establish the appropriate ratio of supervisory to non supervisory positions for the Veteran Integrated Service Network offices as required by VA policy and ensure the Veterans Integrated Service Network offices move toward compliance with these guidelines at the earliest feasible point possible.**

VHA Comments

Concur

VHA will develop a ratio of supervisory to non-supervisory staff (to include administrative support) for VISN Offices. The ratio will set limits for administrative support. VISNs will require DUSHOM approval to vary from the established limits. VISNs will implement required changes to their organizations.

In process	Framework to be developed by June 30, 2012
	VISN Offices to complete their reviews and identify changes needed in VISN by September 30, 2012, with timelines and milestones in action plan to complete implementation NLT March 30, 2013.

Veterans Health Administration

March 2012

Appendix D   OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Janet Mah, Director Edesha Basa John Carnahan Milan Gokaldas Andrew Hamilton Andrea Lui Kelly Perry Corina Riba Leslie Yuri

Appendix E   Report Distribution

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This report will be available in the near future on the OIG's Web site at
http://www.va.gov/oig/publications/reports-list.asp. This report will remain
on the OIG Web site for at least 2 fiscal years.