Major Management Challenges Identified by the OIG

The Department's Office of Inspector General (OIG), an independent entity, evaluates VA's programs and operations. The OIG submitted the following update of the most serious management challenges facing VA.

We reviewed OIG's report and provided responses, which are integrated within the OIG's report. Our responses include the following for each challenge area:

- ***Estimated resolution timeframe (fiscal year)*** to resolve the challenge
- ***Responsible Agency Official*** for each challenge area
- ***Completed 2008 milestones*** in response to the challenges identified by the OIG
- ***Performance results/impacts*** of completed milestones
- ***Planned 2009 milestones*** along with ***estimated completion quarter***
- ***Anticipated impacts*** of the planned milestones

VA is committed to addressing its major management challenges. Using OIG's perspective as a catalyst, we will take whatever steps are necessary to help improve services to our Nation's veterans. We welcome and appreciate OIG's perspective on how the Department can improve its operations to better serve America's veterans.

The table below shows the strategic goal to which each challenge is most closely related, as well as its estimated resolution timeframe.

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Department of Veterans Affairs

Memorandum

Date: July 16, 2008

From: Inspector General (50)

Subj: FY 2008 Performance and Accountability Report

To: Secretary of Veterans Affairs (00)

1. Attached is the Office of Inspector General (OIG) update of the most serious management problems facing VA, for use as part of the FY 2008 Performance and Accountability Report (PAR). Our staff worked with VA staff to arrange publication of the full OIG report on major management challenges in the PAR.

2. Section 3516 of Title 31, United States Code, requires OIG annually to submit this statement to the Department. The law also states the agency may comment on, but may not modify, the OIG statement. Please ensure that all suggested changes made by the Department are provided to OIG for review prior to incorporating the changes in the PAR.

3. In the past year, the work you, the Deputy Secretary, and I have undertaken to resolve difficult and important problems has forged a strong and cooperative working relationship that has helped us in accomplishing our respective missions. I look forward to working with both of you to complete the implementation of key OIG recommendations in the future.

George J. Opfer

GEORGE J. OPFER

Attachment

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

FOREWORD

America relies on VA to take care of the men and women who have sacrificed so much to protect this Nation. As younger service members return from war in Afghanistan and Iraq, and veterans from earlier wars and peacetime deal with their service injuries along with the challenges of being senior citizens, they turn to VA for the benefits they have earned. VA health care and benefits delivery must be made as effective and efficient as possible, which requires that VA support services—financial management, procurement practices, and information management—must also be strong and secure.

The Office of Inspector General (OIG) seeks to help VA become the best-managed service delivery organization in Government. OIG audits, inspections, investigations, and Combined Assessment Program (CAP) reviews recommend improvements in VA programs and operations, and act to deter waste, fraud, and abuse. Each year, as required by 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 and other relevant Government reports, as well as an assessment of the Department's progress in addressing those challenges.

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

OIG will continue working with VA to address each of these issues. Together we can ensure that the Department will provide the best possible service to the Nation's veterans and their dependents, and that OIG recommendations continue to assist VA in becoming a Government leader in sound management.

George J. Opfer

GEORGE J. OPFER
Inspector General

MAJOR MANAGEMENT CHALLENGES

The Office of Inspector General (OIG) identified the major management and performance challenges currently facing VA. Left uncorrected, these challenges have the potential to impede VA's ability to fulfill its program responsibilities and ensure the integrity of operations. For the most part, these challenges are not amenable to simple, near-term resolution and can only be addressed by a concerted, persistent effort, resulting in progress over a long period of time.

OIG's strategic planning process is designed to identify and address the key issues facing VA. OIG focused on the key issues of health care delivery, benefits processing, financial management, procurement practices, and information management in its *2005–2010 OIG Strategic Plan*. The flexibility and long-range vision in the OIG Strategic Plan are essential in a period of expanding need for VA programs and services. Although the Nation's newest and oldest veterans both face a growing need for VA health care and benefits programs, many of the specific services they need differ, and all of them must be the best possible.

The following summaries present the most serious management problems facing VA in each area and assess the Department's progress in overcoming them. While these issues guide our oversight efforts, we continually reassess our goals and objectives to ensure that our focus remains timely and responsive to changing priorities. *(On these pages, the words "we" and "our" refer to OIG. OIG comments in this report are up-to-date as of November 1, 2008; VA responses were submitted in September 2008. Years are fiscal years (FY) unless stated otherwise.)*

OIG CHALLENGE #1: HEALTH CARE DELIVERY

-Strategic Overview-

The quality of veteran health care is the most critical issue facing the Veterans Health Administration (VHA) today. The effectiveness of clinical care, budgeting, planning, and resource allocation are negatively affected due to the continued yearly uncertainty of the number of patients who will seek care from VA. Over the past 7 years, OIG has invested about 40 percent of its resources in overseeing the health care issues impacting our Nation's veterans and has conducted reviews at all VA Medical Centers (VAMC) as well as national inspections and audits, issue-specific Hotline reviews, and investigations. VHA faces challenges in managing its health care activities, with particular concern noted in the quality of care, mental health needs of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) veterans, and VHA research activities.

OIG CHALLENGE #1A: Quality of Care

OIG continues to assess the quality of care at delivery points throughout VA, with significant challenges noted in access to care for rural health, elder care, credentialing and privileging, the Home Respiratory Care Program (HRCP), and systemic problems with outpatient scheduling and patient waiting times.

The OIG Combined Assessment Program (CAP) inspection process highlights that VHA provides quality health care at many facilities. However, medical and supportive care provided to veterans who do not live close to a facility is less consistently available. OIG finds that veterans who live in rural areas may not have readily available access to specialty care, even at a further distance from their local community. This difficulty in the provision of specialty care across the country means that it is challenging, if not impossible, to provide a standard health care benefit to all enrolled veterans.

In addition, VHA has made only limited progress in addressing the longstanding and underlying causes of problems with outpatient scheduling, accuracy of reported waiting times, and completeness of electronic waiting lists (EWLs). Of concern is VHA's delay in implementing appropriate quality assurance procedures necessary to ensure the reliability of waiting times and waiting lists. Audits of outpatient scheduling and patient waiting times completed since 2005 have identified noncompliance with policies and procedures for scheduling, inaccurate reporting of patient waiting times, and errors in EWLs. Although VHA has recognized the need to improve scheduling practices and the accuracy of waiting times data, no meaningful action has been taken to achieve this goal to date. Nine recommendations in prior OIG audit reports issued in 2005 and 2007 that were agreed to by VHA remain unimplemented, as confirmed by our most recent follow-up work in this area in 2008.

The May 2008 OIG report on Veterans Integrated Service Network (VISN) 3 waiting times determined scheduling procedures were not followed, which affected the reliability of reported waiting times and caused inaccuracies in EWLs. OIG recommended that the Under Secretary for Health establish procedures to routinely test the accuracy of reported waiting times and completeness of EWLs, as well as take corrective action when testing shows questionable differences between the desired dates of care shown in medical records and those documented in VHA's scheduling system. This report and prior reports indicate that the problems and causes associated with scheduling, waiting times, and waiting lists are systemic throughout VHA. Moreover, VHA has not ensured compliance with its policy that patients' preferences for desired appointment dates are documented and that veterans receive appointments within the required timeframes. Scheduling roughly 40 million appointments annually, VHA needs to properly document desired appointment dates and ensure patient waiting times are accurate. This is not only a data integrity issue in which VA reports unreliable performance data; it affects quality of care by delaying—and potentially denying—deserving veterans timely care.

A separate, but nevertheless urgent, issue relates to the improvements needed in VHA's credentialing and privileging process. Credentialing refers to the process by which health care organizations screen and evaluate medical providers in terms of licensure, education, training, experience, competence, and health status. OIG identified that providers' previously undisclosed medical licenses create significant problems due to their unmonitored status. OIG also found significant deficiencies in the privileging of physicians, which is the process by which physicians are granted permissions by the medical center to perform specific diagnostic and therapeutic procedures. Providers' privileging for diagnostic and therapeutic interventions is not always appropriate to the capabilities of the medical staff and facilities. Over time, VHA has developed extensive and detailed procedures for credentialing and privileging; however, standardization of these processes and adherence to VHA guidance must be improved to ensure appropriately qualified staff.

Although much appropriate attention has been focused on younger, more recent combat veterans, a large percentage of veterans who are dependent on VA for care are those elderly veterans who are in contract community nursing homes (CNHs). Vulnerabilities in this important program continue to exist, including lack of program oversight, lack of standardized inspection procedures, and inconsistency in local VA medical center review team composition and processes, including the regularity and documentation of visits.

To cite a specific example of quality of care issues identified by OIG oversight work, audits of VHA's HRCP found that VHA facilities had not established home respiratory care teams or completed quarterly program reviews as required. Facility staff did not timely and consistently complete patient reevaluations,

patient home visits, or vendor quality assurance visits. OIG identified a need for facilities to strengthen oversight and contract administration to ensure the delivery of quality care and services, and reduce unsupported or improper payments. OIG projects that VHA had approximately $3.4 million in unsupported costs and improper payments during the 12-month review period and that an estimated $16.8 million in unsupported costs and improper payments could occur in the next 5 years if contract administration is not strengthened.

VA's Program Response to OIG Challenge #1A: Quality of Care

ESTIMATED RESOLUTION TIMEFRAME: FY 2009 and beyond

GOAL: Improve Quality of Health Care

Responsible Agency Official: Principal Deputy Under Secretary for Health

Completed FY 2008 Milestones	Performance Results/Impacts
Reorganized VHA's **clinical quality** and **performance** and **patient safety** programs. Created a **new Office of Quality and Safety** to provide enhanced coordination and oversight of the Office of Quality and Performance and the National Center for Patient Safety to coordinate and compile multiple sources of clinical quality, performance, and safety data developed within and outside VHA.	**Formal structures** have been established for the work of these program offices to be informed by work of other programs, such as the National Surgical Quality Program.
Reorganized the Under Secretary's Coordinating Committee for Quality and Safety (USCCQS) to **engage** significant **stakeholders**, formalize data flows to the Committee, and track follow-up to Committee action items.	The USCCQS provides a clear **focal point** for information flow to senior leadership, decision making, and follow-through on action items.
Established a formal Advisory Committee, consisting of VHA's leading academic clinicians in the area of clinical **quality measurement** and improvement and patient safety, to provide consultation, advice, and input.	The Committee was organized in July 2008 and will meet again in September and quarterly thereafter; it will provide consultation, advice, and input to VHA's Office of Quality and Performance.
Published a **"Hospital Quality Report Card"** in June 2008 that detailed facility performance, including waiting times, staffing, nosocomial infections, satisfaction, quality of care, procedural volume, patient safety, availability of services, and accreditation, across multiple dimensions including age, gender, race/ethnicity, rural vs. urban, and intensive care units.	Report Card resulted in greater accountability and transparency of VA quality and performance, improved the ability to identify potential problems in high-risk groups of veterans, and identified disparities in health that may be amenable to system interventions.

GOAL: Improve Quality of Health Care Responsible Agency Official: Principal Deputy Under Secretary for Health	
Completed FY 2008 Milestones	Performance Results/Impacts
For Non-VA Care Services, began a **demonstration pilot, Project Healthcare Effectiveness through Resource Optimization (HERO)**, to address quality of care for non-VA providers through quality standards included in the Project HERO contracts. Project HERO monitors provider accreditation status, patient safety, access to care, and clinical information exchange for inpatient and outpatient episodes using 79 industry-standard quality metrics.	This is the **first large-scale attempt** to place high quality standards on a significant portion of services provided to veterans outside of VA facilities. This also assists in improving the level and quality of service provided to veterans.
VHA disagrees with the OIG assessment that appropriate implementation of quality assurance procedures to ensure reliability of wait times and wait lists has been delayed. VHA dramatically improved trend in access, which is independent of the issue of measures for wait times, and has implemented the following initiatives to address quality assurance measures for wait times and wait lists. • Established formal **scheduler national training program** requiring successful completion of training for employees to be permitted access to menu options for creating outpatient appointments, making entries to the electronic wait list (EWL) and the Primary Care Management Module (PCMM). • Required **audit** of **scheduler performance** at the local level by supervisors consistent with VHA Directive 2006-055. In addition, VHA periodically requires review by facilities of patients waiting in excess of 30 days.	Trained over 48,000 unique employees, and certified all individuals with access to the menu packages were identified and trained in FY 2007 and 2008. On-going training has proactively identified scheduler errors and enhanced veteran satisfaction.
• Implemented **No Veteran Left Behind** initiative to reduce primary care wait time and electronic wait lists.	New Patient Wait Times improved and EWL decreased.
• Implemented s**cheduler training module** to provide uniform training in scheduling and restricted access to the scheduling package only to schedulers who completed the training.	Reduced scheduling errors.

GOAL: Improve Quality of Health Care Responsible Agency Official: Principal Deputy Under Secretary for Health	
Completed FY 2008 Milestones	Performance Results/Impacts
• Hired outside consultant to provide recommendations on **wait time measurement**. • Convened expert panel to revise the **Scheduling Directive**.	Consultant recommendations and the finalization of new Scheduling Directive will refine identified waiting times measurement issues.
• Identified multiple **software problems** related to **documentation of desired appointment date**. These issues include field limitations for desired date change explanations, lack of a data field to ensure consistent location in **Computerized Patient Record System (CPRS)** for providers to enter desired date for an appointment or a consult, and lack of consistent display of desired date documentation on the scheduler Veterans Health Information Systems and Technology Architecture (VistA) screen.	Resolution of these issues will **create functionality** within CPRS for **documentation** by providers of desired dates for appointments and consults, to link these entries to the appointment package, and **display** this **information** for **schedulers** to view while creating appointments. In addition, a new multiple choice field was added for schedulers to indicate why changes from provider instructions are made to desired date.
• Implemented national software that **links consults creation date information to scheduled appointments.**	Provides reports on **wait times** from consult requests to appointment creation, to appointment completion, and in addition, provides wait times from desired date. Because of variation in business practices and in use of the consult package, the **clinical meaning** of this information is being **evaluated** at the local level.
• Reviewed comprehensive lists of consults identified as **not properly closed out**. Found a multitude of reasons why consults did not result in a scheduled appointment or a listing on the EWL. Also found that the CPRS consult software application has been adopted by providers system-wide for many purposes other than purely the purpose of requesting clinical consultation. Providers have been using this software to request approval for use of non-formulary drugs, purchase of prosthetics, inpatient EKGs, DVA van travel, etc.	Publishing a **new Consult Directive** will define clinical consultation and distinguish it from other uses of the consult package.
• Recognized a nation-wide problem with **inconsistent hiring practices** including grade variation resulting in high turnover and lack of promotion potential. At some locations, schedulers are hired at the GS-2 & GS-3 level, while they are hired at the GS-6 level at other locations.	Finalizing a **career ladder national scheduler position description**, to standardize grades and clearly define the levels of complexity at different grades for schedulers.

GOAL: Improve Quality of Health Care Responsible Agency Official: Principal Deputy Under Secretary for Health	
Completed FY 2008 Milestones	Performance Results/Impacts
Improved access to care **for new mental health patients**.	At the end of FY 2007, a target was set for completing full evaluation and development/initiation of a treatment plan for all new patients within 15 days – as of June 2008, **more than 90 percent of new patients** now have a completed evaluation and treatment plan within 15 days of first being seen.
Provided teleretinal screening of veterans at 229 locations (includes VAMCs and CBOCs) in VA.	Improved veteran access to a validated technology-based system for the prevention of avoidable blindness due to diabetes while providing diabetic health education with the goal of better self-management of the disease. This is a new system implemented in VA that has screened more than 200,000 veteran patients, principally in primary care. This gives VA the greatest experience worldwide and provides convenient local access to services that help prevent avoidable blindness.
Reviewed Spinal Cord Injury (SCI) Center Clinic access expectations with SCI Leadership.	99 percent of SCI Center appointments between January 2008 and March 2008 were seen within 30 days.
Implemented improvements to the process of medical staff appointments including providing system-wide education on standards and requirements for credentialing and privileging, instituting triggers for automatic review of malpractice actions, and instituting procedures to identify all medical licenses held by a provider.	Improved ability to identify potential problems with licensed providers even if they fail to personally disclose all licenses.

GOAL: Improve Quality of Health Care Responsible Agency Official: Principal Deputy Under Secretary for Health	
Completed FY 2008 Milestones	Performance Results/Impacts
Established the Office of Rural Health (ORH) to improve access to quality health care for rural veterans. FY 2008 actions included the following: • **Implemented Mobile Health Care Pilot Project** at four VISNs to operate mobile health care units. • **Created Ten New Outreach Clinics** to extend access to on-going primary care and mental health services for veterans in rural and highly rural areas. • **Established a Veterans Rural Health Advisory Committee** to examine ways to improve and enhance VA health care services for rural veterans and to make recommendations to the Secretary. • **Initiated a Web-Based Curriculum** for a training program on providing geriatric medicine in rural VA clinics. • Expanded **Home-Based Primary Care** and the **Medical Foster Home** program into areas serving rural veterans. • **Veterans Rural Health Resource Centers:** With sites selected in FY 2008, the Resource Centers will serve as full-functioning satellite offices for ORH. The Resource Centers will contribute a highly meaningful perspective to the work of ORH from their locations in three separate areas of the United States – western, central, and eastern – that serve large rural and highly rural veteran populations.	Through the ORH, VHA's capacity to provide health care to veterans close to where they live is enhanced through these projects; at the same time, veterans living in rural areas have improved access to health care.
Increased the number of VA facilities equipped with **video teleconferencing** (VTC) equipment from 349 at the end of FY 2007 to 385 by Quarter 3 of FY 2008.	VTC units in more than 30 specialty areas enabled VA to deliver care to veterans in rural areas or where services were scarce, with the majority of visits occurring for mental health services.
Care Coordination Home Telehealth (CCHT) services are currently implemented in more than 148 VA sites nationally. More than 40 percent of the 34,000 patients currently receiving care via CCHT live in rural and remote areas.	CCHT programs allow VA health care providers to care for patients in their homes without geographical or travel barriers.

GOAL: Improve Quality of Health Care Responsible Agency Official: Principal Deputy Under Secretary for Health	
Completed FY 2008 Milestones	Performance Results/Impacts
Developed Amputation System of Care (ASC) proposal to integrate with existing Polytrauma systems of care. Amputation Regional Centers to provide highest level of **specialized expertise** to the most complex patients; Amputation Network Sites to provide full range of clinical and ancillary services.	This ASC will provide a system in which veterans will find the amputation state-of-the-art care expertise they require. This model of care was developed in response to the growing demand for amputation services within the VA system. The ASC will use an interdisciplinary team approach; state of the art technology in evaluation, fabrication, and fitting of prosthetic limbs; and expertise in the prescription, provision, and training of the newest technology in prosthetic limbs.
Approved a **fifth Poly Trauma Center (PRC)** for **San Antonio**. The architectural and engineering contract has been awarded and design is underway.	The PRC in San Antonio will provide coordinated, comprehensive, and integrated care to veterans who require **state-of-the-art rehabilitation** services. Construction of the PRC in San Antonio was approved to geographically expand these services for the veterans and military population in the southwest region of the country. Veterans in this region of the country are presently served by the PRCs in Tampa, Florida, or Palo Alto, California.
Assessed the **Emerging Consciousness Program** (ECP) and developed a proposal for enhancements to the program with regard to new technology, therapeutic interventions, and clinical and research protocols.	The ECP program promotes **return to consciousness** and will facilitate progress to the next level of rehabilitation care for individuals with ongoing disorders of consciousness secondary to severe traumatic brain injury (TBI).
Developed a code proposal to revise International Classification of Diseases, 9th Revision, Clinical Management (ICD-9-CM) coding.	If approved by the World Health Organization, the proposed code will improve uniform symptom codes and diagnostic classification, tracking, reporting, and research related to TBI.
Formalized a policy whereby **Spinal Cord Injury and Disorders (SCI/D)** Home Care staff will provide outreach to veterans with SCI/D in community nursing homes.	SCI Home Care staff serves as a resource to community nursing homes providing **consultative care** and education in caring for person with SCI/D, specifically skin and bowel and bladder care issues.
Established **Home Respiratory Care Program** (HRCP) at all medical facilities and established four national performance measures to measure progress.	Increased oversight of HRCP by improving communication between Home oxygen clinicians, therapists, and prosthetics staff and establishing HRCP monthly/quarterly meetings as an avenue for addressing any identified patient, administrative, or clinical issues.
Provided **training** to Prosthetic representatives PR and Chief Medical Officers (CMO) on HRCP administrative policies and procedures.	Improved understanding of HRCP policies and procedures and ensures compliance with program requirements.
Established a monitoring mechanism using the Prosthetics Home Oxygen Software to track renewal/expiration dates of patient prescriptions and ensure that all new Home Oxygen patients comply with existing requirements.	Increased compliance with Clinical Practice Recommendations on medical documentation and prescription criteria with an overall average of 97.09 percent in VISN compliance, thus reducing the number of expired prescriptions considerably.

GOAL: Improve Quality of Health Care Responsible Agency Official: Principal Deputy Under Secretary for Health	
Completed FY 2008 Milestones	Performance Results/Impacts
Developed a policy to allow those with **Power of Attorney (POA)** and legal guardians to perform in-person authentication in lieu of the veteran via My HealtheVet (MHV).	This development has improved quality of care by allowing POAs and legal guardians to have access to MHV to order medications online for the veteran, view appointments and reports, and conduct secure messaging.

GOAL: Improve Quality of Health Care	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Refine and reissue **Hospital Quality Report Card** on an annual basis. **(Q4)**	Enhance **accountability** and **transparency**. Improve ability to identify potential problems in high-risk groups of veterans. Reduce gaps in performance.
Develop and issue national standards for **provider privileging** to ensure appropriate alignment with medical staff and facility capabilities. **(Q4)**	Ensure clinical procedures are performed by appropriately qualified staff in facilities capable of fully addressing expected and unexpected needs of patients.
Support the following initiative to provide health care to veterans living in rural areas: **Native American/Alaska and Hawaii Natives Initiative** – To identify barriers to access to health care services faced by this population of rural and highly rural veterans, with particular attention to the need to accept and incorporate their traditions. ORH will promote care for these veterans. **(Q4)**	VHA's capacity to provide health care to veterans close to where they live will be enhanced through these partnerships and initiatives.
Revise training for schedulers based on new **Scheduling Directive**, new **Consult Directive**, and scheduling process modeling group. **(Q4)**	The training and the directives will improve accuracy in scheduling appointments for veterans.
Begin work, through the chartered **business process modeling** group, to recommend standardized processes, perform gap analyses, and develop training tools pertaining to the scheduling process. **(Q4)**	Anticipate improved standardized scheduling performance.
Continue collaboration with the Office of **Geriatrics and Extended Care** to expand on various quality management tools for use in the community nursing home program. **(Q4)**	These tools will improve compliance with VHA policies and provide data that will assist with monitoring policy compliance and improve quality of care by permitting analysis of direct measures of quality in nursing homes (such as staffing levels, scope and severity of deficiencies, improvements in skin care, and bowel & bladder issues).
Implement **Amputation System of Care** (ASC) program. **(Q4)**	The ASC will provide specialized expertise in **amputation rehabilitation**, incorporating the latest practice in medical rehabilitation management, rehabilitation therapies, and technological advances in prosthetic components.

GOAL: Improve Quality of Health Care	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Implement a "**Polytrauma Marker**" in its patient data files, which will be supported by consensus operational and computable definitions of polytrauma and TBI. **(Q4)**	The marker along with other databases will identify the cohort of veterans with **polytrauma** and **TBI**; will provide information regarding service utilization; will facilitate **tracking** of patients; and help plan for their long-range care needs.
Develop **Clinical Practice Guidelines for TBI** care. **(Q4)**	VHA clinicians will have access to the most current evidence-based recommendations for the **diagnosis** and **management** of patients with mild **TBI**, leading to improved treatment and health care outcomes for veterans.
VA will continue to implement the **Blind Rehabilitation Continuum of Care** for Visually Impaired Veterans. **(Q4)**	The Continuum of Care will **expand services** for visually impaired veterans and provide treatment with the latest technological devices for all veterans and servicemembers with vision-related deficits who need rehabilitation training.
Add two sites, one in San Juan, Puerto Rico, and one in San Antonio, Texas, to the **Polytrauma Telehealth Network**. **(Q4)**	These two sites will **improve access** to specialist services for OEF/OIF combat-wounded veterans.
Establish four Home Respiratory Care Program metrics in the areas of medical documentation and prescription criteria, expired prescriptions, verification of equipment delivery and vendor billing, and quarterly home oxygen visits. **(Q4)**	Improve monitoring and prompt renewal of **prescriptions**, increase **accountability** and management of home oxygen contracts, and reduce improper payments. Will increase home visits to oxygen patients.

OIG CHALLENGE #1B: New and Significantly-Increased Health Problems Associated with OEF/OIF

The health and welfare of millions of battle-tested veterans requires world-class care when these veterans seek care from VHA. Significant improvements have been made to better care for these national heroes, but VHA progress has been slow in appropriately dealing with mental health care, suicide prevention, and aid for homeless veterans.

Providing appropriate mental health care for veterans, especially those returning from recent conflicts in OEF/OIF, is a continuing and significant challenge for VHA. Veterans returning from current conflicts experience Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD) with great frequency. Appropriate, timely, and compassionate care for veterans with PTSD, the physical and psychological effects of TBI, and the impact of these problems on the family will continue to be major issues for VHA.

In 2007, OIG published a national report on VHA's mental health strategic plan initiatives on suicide prevention, along with a number of single case reviews of the care of patients who committed, or were thought to have committed, suicide. Current education initiatives to train first contact non-clinical personnel about crisis situations involving veterans at risk for suicide have yet to be implemented at all VA facilities. Of the programs implemented, fewer than half include mandatory training on suicide response protocols.

VA has devoted significant resources to homeless veterans, especially by homeless grant and per diem programs. Nevertheless, veterans who are homeless need more than just a home, and OIG continues to review VA programs designed to assist veterans at risk because of their homelessness or other lifestyle characteristics. Homeless veterans need health care, mental health care, and the support and social services to ensure education, jobs, and the permanent housing that can result from a more stable life.

VA's Program Response to OIG Challenge #1B: New and Significantly-Increased Health Problems Associated with OEF/OIF

ESTIMATED RESOLUTION TIMEFRAME: FY 2009 and beyond

GOAL: Improve Quality of Health Care for OEF/OIF Veterans

Responsible Agency Official: Principal Deputy Under Secretary for Health

Completed FY 2008 Milestones	Performance Results/Impacts
In May 2008, a call center became operational that will reach two distinct populations of OEF/OIF veterans: • Those veterans who had prior use of military or veteran health care services. This population is approximately 15,500. • All OEF/OIF veterans who have been discharged from the military, but have not yet engaged VA for health care services. This population is approximately 550,000. By the fall of 2008, the call center will have reached all of the above veterans.	OEF/OIF veterans are informed about changes in VA services and benefits to which they are entitled. This outreach activity may prompt new veterans to come to VA for health care before a symptom or non-acute issue becomes a serious health care condition.

GOAL: Improve Quality of Health Care for OEF/OIF Veterans Responsible Agency Official: Principal Deputy Under Secretary for Health	
Completed FY 2008 Milestones	Performance Results/Impacts
Provided VA Support to Demobilizing Reserve Component (RC) Servicemembers: In May 2008 the VA Outreach Office initiated a demobilization initiative to inform demobilizing RC combat servicemembers of their enhanced VA health care and dental benefits, to offer them assistance in completing the enrollment application form (1010EZ), to collect the completed forms during their mandatory demobilization separation briefings, and match the DD214 with the 1010EZ for registering into the system and to initiate enrollment into VHA care.	This facilitated enrollment helps by getting the administrative details of enrollment into VA healthcare out of the way prior to the veteran's arrival for his/her first appointment. This will improve access and utilization by OEF/OIF combat veterans.
Collaborated with DoD on Post Deployment Health Reassessments (PDHRAs): The Department of Defense screens servicemembers 4 to 6 months after returning from duty in the combat zone for indicators of possible mental or physical disorders. Members who screen positive for a possible condition are referred to a definitive medical facility for further evaluation.	Since November 2005, VA has had employees on-site to provide information on VA care and benefits, to enroll interested Reservists and Guard members in the VA healthcare system, and to arrange appointments at VA healthcare facilities for referred servicemembers or veterans. Since inception, over 94,000 Reserve and Guard members have completed the PDHRA on-site screening resulting in over 22,000 referrals to VA facilities and over 11,000 referrals to Vet Centers for further evaluation.
Allocated more than $360 million for mental health enhancements, specifically for **suicide prevention** efforts.	Through the Mental Health Enhancement Initiative (2004-2008) and the congressional supplemental funding, over 4,000 new positions have been added for mental health services. Of the new positions, 381 are for suicide coordinators, case managers, and/or support staff to directly support suicide prevention efforts. Another important focus has been promoting access to mental health services. As of July 31, 2008, 151 of 153 medical centers have expanded clinic hours for mental health services. Nationally, we are at 93 percent compliance for conducting more comprehensive evaluations and initiating treatment within 14 days for new referrals to mental health.
Required mandatory **training on suicide prevention** for all non-professional staff with patient contact.	Developing Project Save as a training tool, which establishes mechanisms for **Suicide Prevention Coordinators** to track staff training.

GOAL: Improve Quality of Health Care for OEF/OIF Veterans Responsible Agency Official: Principal Deputy Under Secretary for Health	
Completed FY 2008 Milestones	Performance Results/Impacts
Expanded the **Suicide Prevention Hotline**. Current workload is about 250 calls/day.	The Hotline is staffed 24/7 with clinicians who have real-time access to a veteran's record if the veteran receives or has received care through VA. Hotline staff performed over 1,800 rescues – no doubt saving many lives.
Evaluated **suicide rates** among veterans, and used this information to plan policy and practice.	**Observations** from 2002-2006 that suicide rates are as follows: 1) Rates among OEF/OIF veterans are not greater than age-, sex-, and race-matched individuals from the general population. 2) Rates among veterans of all eras receiving VA health care are approximately 1.6 fold greater than individuals from the general population.
Established 23 new Vet Centers and augmented the clinical staff at 64 existing Vet Centers in FY 2008. This program enhancement increased the number of Vet Centers from 209 to 232, and added 150 additional staff members.	Increased capacity to provide **outreach** and **readjustment** counseling assures increased access to returning OEF/OIF combat veterans and families, while meeting workload demand from eligible combat veterans from other conflicts.
Hired 100 GWOT **outreach specialists** that are providing outreach services to OEF/OIF veterans as they return from combat at Active Military, National Guard, and Reserve **demobilization sites**.	Increased capacity for **aggressive outreach** to OEF/OIF veterans assures adequate access to care for new combat veterans and family members.
Trained all Vet Center service providers on **motivational interviewing** techniques to use when working with substance using veterans.	Improved effectiveness of Vet Center staff for delivery of readjustment counseling to substance using veterans, a frequent co-morbid condition to war-related PTSD.
Completed **mandatory training** in **traumatic brain injury (TBI)**, for mental health professionals and began using the standard TBI clinical screens as part of Vet Center intake assessments.	Improved **capacity** among Vet Center service providers to detect possible TBI and make **timely referrals** to VA medical facilities.
Provided **Gatekeeper** training for all Vet Center staff; the training was based on a model developed by the U.S. Air Force for early detection of **suicide risk**, and on means for effective and timely intervention.	Improved effectiveness of Vet Center suicide prevention efforts will enhance crises response outcomes and will ultimately **save veterans' lives**.
Developed and piloted a **public information campaign** for prevention of veteran suicides.	**Increased awareness** of veteran suicides as a public health problem, improved coordination of care with community providers, and increased calls to the VA Suicide Prevention Hotline.

GOAL: Improve Quality of Health Care for OEF/OIF Veterans Responsible Agency Official: Principal Deputy Under Secretary for Health	
Completed FY 2008 Milestones	Performance Results/Impacts
Implementing two initiatives to disseminate **evidence-based psychotherapies** for PTSD throughout VA health care system.	These initiatives involve providing clinical training to VA mental health staff in the delivery of Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE). As a result, as of the end of July 2008, over 1,000 VA mental health clinicians have been trained in CPT or PE.
Established a national **PTSD Mentoring Program** to provide training and support in PTSD program development and management with the goal of improving PTSD treatment and clinical outcomes.	Each VISN has selected mentors and participants, or mentorees, who will be working together toward improved communication and program development goals in PTSD treatment within their home VISNs. A VA National Mentoring Program Web site has been established to disseminate information to all VA staff working within the field of PTSD treatment. National calls are held monthly with the mentors and with a steering committee for the mentoring program.
Engaged the **Institute of Medicine (IOM)** to evaluate the long-term health consequences of TBI, with a particular focus on mild and moderate TBI, for veterans of OEF/OIF. Study is part of a National Academy of Sciences' comprehensive review and evaluation of the available scientific and medical information regarding the health status of Gulf War veterans.	Provides a comprehensive review and evaluation of the available scientific and medical information regarding the health status of Gulf War veterans.
Developed a **Web-based application** to track the number of veterans who have **screened positive** for possible TBI, the number referred for follow-up evaluation, and the number who have completed follow-up evaluation.	Provides the **database** necessary to **monitor** the completion of the **TBI screenings** and **TBI evaluations** and provides the framework for addressing problems at the network and facility levels.
In collaboration with **DoD,** sponsored a State-of-the-Art **Conference on Approaches to TBI Screening, Treatment, Management, and Rehabilitation**.	Provides the framework to make recommendations for further research, policy, or processes that will address gaps in knowledge and improve **quality of outcomes** of VA TBI care.
Began work to establish an **interagency agreement** with the **Department of Education** to coordinate with National Institute on Disability and Rehabilitation Research on research related to the rehabilitation of individuals with TBI.	This research will translate evidence-based practices into the development of new clinical interventions.
Developed the **Family Care Map** – a Web-based clinical tool for use by Poly Trauma Center (PRC) multidisciplinary clinical teams and families.	The Family Care Map seeks to **standardize and improve support** for family members while their veteran is undergoing inpatient rehabilitation at a PRC.

GOAL: Improve Quality of Health Care for OEF/OIF Veterans Responsible Agency Official: Principal Deputy Under Secretary for Health	
Completed FY 2008 Milestones	Performance Results/Impacts
Implemented the Blind Rehabilitation Service Continuum of Care for **visually impaired veterans** across VA to serve approximately 12,075 patients with low vision annually. Fifty-five new outpatient low vision and blind rehabilitation clinics have been planned and are being implemented nationally.	The Continuum of Care will **expand services for visually impaired veterans** and provide treatment with the latest technological devices for all veterans and servicemembers with vision-related deficits who need rehabilitation training.
Established the **Federal Recovery Coordinator (FRC) Program** as a joint VA/DoD program with a Federal Recovery Coordinator assigned to oversee and coordinate services for **catastrophically wounded** OEF/OIF servicemembers. Nine FRCs are in place and serving 88 servicemembers.	Improved access to all clinical and non-clinical care for catastrophically wounded OEF/OIF servicemembers/veterans/families.
Began OEF/OIF **Care Management Program** at the facilities to coordinate care provided to veterans and family members with a nurse or social worker case manager. 100 Transition Patient Advocates also support severely injured or ill OEF/OIF veterans by acting as an advocate for the patient and family as they move through VA's system of care. As of July 2008, 1,698 severely injured OEF/OIF veterans and active duty servicemembers receive care management services.	Care of all severely ill and injured OEF/OIF servicemembers and veterans is well-coordinated by a designated healthcare facility OEF/OIF Care Management team. Improved communication with family members.
Increased **VA Liaison** staffing at nine **Military Treatment facilities**.	Meets increased workload and facilitates transfer of OEF/OIF servicemembers from VA to DoD.
Developed, together with DoD, a proposal to add new ICD-9-CM codes to better describe mild, moderate, and severe traumatic brain injury (TBI), as well as codes to represent the effect of TBI that are not immediately known (late effects). Proposal has been endorsed by the National Center for Health Care Statistics for presentation to the ICD-9-CM Coordinating and Maintenance Committee in September 2008.	The adoption of these codes will improve patient safety, quality of care, and public health. It will also be a positive impact on the value of health care data for patients suffering from TBI with medical decisions made based on accurate and precise data.
Provided training opportunities for Homeless Grant and Per Diem Program Liaisons on grant recipient oversight, program monitoring, case management, and development of performance measures focused on providing access for those veterans with substance use disorders and/or diagnosed with a mental illness.	As noted in congressional testimony, there has been a dramatic decline in the homeless population.

GOAL: Improve Quality of Health Care for OEF/OIF Veterans	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
The Readjustment Counseling Service (RCS) will establish an additional **39 new Vet Centers** by the end of FY 2009. This program enhancement will increase the number of Vet Centers from **232 to 271**, and increase Vet Center staffing by 174 positions. **(Q4)**	Increased Vet Center capacity will ensure that combat veterans and family members seeking readjustment counseling will receive adequate care.
On a pilot program basis, RCS will implement a **24/7 informational call center** to be manned by **combat veterans** to extend further outreach to OEF/OIF veterans. **(Q4)**	Distinct from a clinical crisis line, the call center will promote **rapport** with fellow combat veterans and provide them with information needed to access VA services.
Implement components of the Uniform Mental Health Services Handbook related to PTSD care as well as other mental health problems. **(Q4)**	Multiple metrics are being developed and will be applied to evaluate the impact of this implementation. As one example, full implementation should result in all women veterans having access to a woman therapist for care of PTSD related to Military Sexual Trauma if that is their preference.
Further expand training in **Cognitive Processing Therapy** (CPT) and **Prolonged Exposure** (PE) therapy for PTSD. **(Q4)**	**Doubles the number of VA mental health staff** trained in CPT and PE therapies to 2,000 by the end of FY 2009, and promotes greater veteran access to evidence-based treatment.
Provide for CPT or PE in every medical facility for every eligible veteran with PTSD who requests or agrees to one of these therapy approaches as mandated in the Uniform Mental Health Services Handbook. **(Q4)**	Metrics will be developed to ensure full availability of these two therapies.
Identify in Care Management Record Tracking Application active duty, enrolled, and not enrolled veteran specialty users (amputees, burns, blind). **(Q1)**	Improves and ensures knowledge of VA healthcare and care management services as needed through an active listing of specialized OEF/OIF population.
Expand Care Coordination Services (CCS) Telemental health care for OEF/OIF Veterans: Based on current estimates, about 50,000 unique veterans will receive **mental health care** via **clinical video teleconferencing** in FY 2009. **(Q4)**	The expansion in **telemental** health programs will increase access to delivery of care to OEF/OIF veterans needing mental health services.
Implement **telehealth technology** to support care/case management of combat wounded veterans through development and implementation of a telerehabilitation **disease management protocol**. **(Q2)**	Care/case management of veterans needing rehabilitative services using telehealth technologies in their homes will result in the **proactive recognition and treatment** of clinical care issues.

GOAL: Improve Quality of Health Care for OEF/OIF Veterans	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Continue to refine plan for **facilitating transition** from institutional care to the home, and for ensuring long-term care needs of severely injured OEF/OIF veterans. **(Q4)**	Several initiatives address the continuum of long-term services for veterans with polytrauma and TBI. These include: medical foster home care, assisted living pilot program, implementation of the rehabilitation and reintegration plan of care for every veteran with TBI, and in-home monitoring using telehealth.

OIG CHALLENGE #1C: Research

Congressional interest over reported problems in VHA research programs underscores the need for continued OIG oversight of this high priority issue. OIG issued several reports in 2007 and 2008 that highlight VHA deficiencies in human subjects protection and research funds administration. It is imperative that VA researchers comply with policies and procedures that protect patients, ensure sound scientific results, and provide transparent fiscal accountability.

Throughout 2007 and into 2008, OIG has continued to highlight problems with human subjects protection in VHA research. Both Federal and VHA policies require that all research involving human subjects be approved by an Institutional Review Board (IRB), that research subjects give informed consent, and that institutions provide assurances of regulatory compliance. VHA Handbook 1200.5, *Requirements for the Protection of Human Subjects in Research*, adopted July 15, 2003, outlines VHA policy for the ethical conduct of research involving human subjects. A number of reports have focused on systemic problems with IRB oversight of human subjects protection; others have focused on individual Principal Investigators who did not properly adhere to VHA research policy in the area of human subjects protection. Many of these deficiencies revolve around informed consent, verification that subjects recruited met inclusion or exclusion criteria, and the reporting of adverse events to the IRB.

The 2008 audit of VHA controls over the administration of funds for research and education activities at VA's Nonprofit Corporations (NPCs) revealed significant vulnerabilities. The audit found that the NPCs did not implement adequate controls to properly manage funds, safeguard equipment, and guard against conflicts of interest. VHA did not establish clear lines of authority, provide effective oversight, or require minimum control requirements. As a result, VHA does not have reasonable assurance that NPCs fully comply with applicable laws and regulations or that they effectively manage research and education funds.

VA's Program Response to OIG Challenge #1C: Research

ESTIMATED RESOLUTION TIMEFRAME: FY 2009 and beyond

GOAL: Improve Protection of Human Subjects and Administration of Research Funds

Responsible Agency Official: Principal Deputy Under Secretary for Health

Completed FY 2008 Milestones	Performance Results/Impacts
The Office of Research and Development (ORD) carried out formal education program to ensure compliance with necessary law and VA policies. Held six local accountability meetings. The Office of Research Oversight (ORO) sponsored a major review project to ensure that Institutional Review Board (IRB) informed consent concerns are evaluated and corrected in one facility in VA.	ORO increased emphasis on its VA evaluations to ascertain if audits are being done to ensure informed consent adequacy.
Created a requirement that Privacy Officers and Information Security Officers be non-voting members of VA IRBs.	Revised policy will emphasize the necessity and appropriateness of adverse event reports to IRBs and ORO.
Increasing emphasis on VA evaluations to ascertain if audits are being done to ensure informed consent adequacy.	Revision of Handbook 1058.1 will emphasize the necessity of adverse event reports to IRBs and to ORO.

GOAL: Improve Protection of Human Subjects and Administration of Research Funds

Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Will develop an **education program** to assist Research Compliance Officers in developing and improving authorized audits and frequent evaluations of informed consent in VA research compliance. Planned actions emphasize critical topics such as informed consent and auditing requirements in current policy. **(Q4)**	The education program will assist Research Compliance Officers to fulfill their increased duties.
Will **revise policies and procedures** requiring additional detail in VA research auditing by October 2009. ORD also plans completion of edition of VHA Handbook 1200.5 by December 31, 2009. **(Q4)**	The revised policies and procedures will specify requirements for research auditing compliance in each facility.
With the expansion of the auditing done in VA research, the appropriateness of the informed consent will be systematically noted. Will **expand emphasis on auditing** requirements in current Directives. **(Q4)**	The expansion of auditing will ensure increased protection of human subjects and give the subjects a greater awareness of the benefits and risks of research.

GOAL: Improve Protection of Human Subjects and Administration of Research Funds	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Will sponsor a major program for more than 600 VHA research staff that will emphasize critical topics such as informed consent. **(Q2)**	The education program will promote a culture of awareness of requirements and compliance. The program will involve Medical Center Directors, Chiefs of Staff, Associate Chief Officers for Research and Development, Research Compliance Officers, and Administrative Officers.

OIG CHALLENGE #2: BENEFITS PROCESSING

-Strategic Overview-

Large inventories of pending claims for compensation and pension benefits have been a problem for many years. Making headway has proven difficult because VA faces an increasing disability claims workload from returning OEF/OIF veterans, reopened claims from veterans with chronic progressive conditions, and additional claims from an aging veteran population. The complexity of benefits laws, court decisions interpreting those laws, technology issues, workload, and staffing issues contribute to VA's benefit processing challenges. Increases in VA funding levels have enabled VA to hire additional claims examiners to help reduce the backlog of pending claims, but VA now faces a challenge to train and incorporate them effectively into a productive workforce. With the significant expansion of its claims workforce through current recruitment efforts, the loss of seasoned claims processing staff, and increasing receipt of claims from veterans, VA will face additional significant challenges in the accuracy and consistency of benefit decisions. OIG oversight in the form of audits and investigations provides recommendations for improvement in timeliness, quality, internal controls, and work to reduce the volume of improper payments.

OIG Challenge #2A: Workload

The Veterans Benefits Administration (VBA) anticipates receiving 872,000 rating-related claims in 2009, which represents a 51 percent increase from 2000. Through May 2008, however, VBA has reversed the trend of receiving more claims than they have completed, with completed rating-related claims exceeding receipts by over 5,000. They also reduced pending non-rating-related claims over the previous year. This indicates some progress in reducing claims backlog. VBA will be challenged to maintain and improve on this performance while aggressively recruiting in order to complete its planned expansion of claims processing staffing by about 25 percent and training the newly hired staff.

At the same time, May 2008 data shows pending appeals increased from a year earlier, which may reflect not only increases in claims filed and completed, but also the continuing complex environment of claims processing in VA compensation and pension monetary benefit programs. According to testimony of Secretary Peake in February 2008, the number of original compensation cases with eight or more disabilities claimed has increased by 168 percent since 2000.

VA's Program Response to OIG Challenge #2A: Workload

ESTIMATED RESOLUTION TIMEFRAME: FY 2009

GOAL: Reduce Claims Backlog and Pending Appeals Backlog

Responsible Agency Officials: Under Secretary for Benefits; Chairman, Board of Veterans' Appeals

Completed FY 2008 Milestones	Performance Results/Impacts
Modified the Veterans Service Representative (VSR) training protocols to **focus new hires** on processing burial and dependency claims to allow them to become productive quickly.	Allowed newly hired VSRs to **become productive quickly** in the areas of burial and dependency claims processing. Freed other more experienced regional office staff for assignment to disability claims processing.
Consolidated original pension benefits (live and death) to the Pension Management Centers (PMCs), formerly the Pension Maintenance Centers.	Allowed regional offices to focus on processing other disability claims.
Began a joint VA and Department of Defense (DoD) **Disability Evaluation System pilot**.	Provides one examination to separating servicemembers, streamlining the disability process for both VA and DoD.
Began **consolidation** of general inquiry phone calls to **nine National Call Centers**.	Allowed regional office personnel to focus on processing disability claims.
Proposed a regulation to implement the **Expedited Claims Adjudication** (ECA) **initiative** to streamline the claims adjudication and appeal process. Regulation allows represented claimants to voluntarily waive certain response timelines, agree to respond quickly to VA requests for evidence, and file any desired appeals in an expedited manner.	Proposed regulation remains under development. The regulation aims to reduce Appeals Resolution Time (ART) for ECA appeals in this 2-year pilot project.
Continued to emphasize **reducing avoidable remands**.	The Board reduced the remand rate from 56.8 percent in FY 2004 to 36.8 percent in FY 2008.
Used **overtime** for writing and dispatching decisions.	In FY 2007 and FY 2008, the Board prepared approximately 2,000 decisions using overtime.
Used **mentoring** and **training** tools to promote efficient case review and decision writing with an emphasis on writing clear, concise, coherent, and correct decisions.	In FY 2008, the Board **retained 95.7 percent** of its 70 new attorneys due to the excellent 1-on-1 mentoring program by senior attorneys and the Board's MCLE accredited classroom training. Retaining attorneys reduces the in-house resources needed to hire, train, and mentor new attorneys and increases productivity at the Board.
Expanded the flex-place program from 88 to 100 for **high-achieving attorneys** who have committed to increasing production.	On average, full-time attorneys in the flex-place program produced 13 more decisions in FY 2008 than full-time attorneys in the office.
Used aggressive hiring practices to **add additional FTE** to address appellate workload.	Increased the number of appeals decided from 40,401 in FY 2007 to 43,757 in FY 2008.

GOAL: Reduce Claims Backlog and Pending Appeals Backlog	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Begin the **consolidation** of certain parts of appeals work, such as Notices of Disagreement ready for decision, to **two Appeals Resource Centers**. **(Q1)**	Will allow regional office personnel to focus on the appeals workload at their station.
Complete the **consolidation** of general inquiry phone calls to **nine National Call Centers**. **(Q3)** **Consolidation of survivor benefit claims processing** to the Pension Management Centers. **(Q4)**	Will allow regional office personnel to focus on claims processing.
Full **implementation** of ECA. Final rule expected. **(Q1)**	Claimants participating in the 2-year pilot program should experience a 25 percent reduction in the length of time they have to wait for a decision on their claim.
Continue emphasis on **reducing avoidable remands**. Reducing the remand rate will **reduce** the **backlog** of appeals since approximately 75 percent of remanded cases eventually return to the Board, slowing the appeal process. **(FY 2009 and beyond)**	The Board's goal is to reduce the remand rate below 35 percent in FY 2009. In FY 2008 the remand rate was 36.8 percent.

OIG Challenge #2B: Quality

Long-term efforts to improve the quality—the accuracy and consistency—of claims decisions continue to present a significant challenge. Recent OIG audit findings indicate accuracy and processing delays have not improved over the past 2 years. May 2008 data shows the accuracy of rating benefit entitlement decisions dropped two percentage points during the preceding 12 months, from 89 to 87 percent. While VBA reports a 2-point improvement in accuracy of non-rating decisions over the same period, the error rates—13 percent in rating decisions—remain unacceptably high. In addition, VBA has not completed all planned actions to address the continuing variance in disability payments among the various states that is within the control of VBA to correct. These quality challenges are especially significant given the size of the benefits program, which exceeds $40 billion annually.

Data retrieval issues also impact the quality of benefits processing. VBA is in the middle of transition of Compensation and Pension benefit claims processing and payment from the legacy Benefits Delivery Network (BDN), which has captured all benefit information for over three decades, to the replacement Veterans Service Network (VETSNET) system, which resides in the corporate database. While full conversion to VETSNET is anticipated by mid-calendar year 2009, currently benefit payments are being made from both BDN and VETSNET, with the vast majority of Compensation payments being made via VETSNET. VBA is still working on transition issues of correctly reporting information that combines BDN and VETSNET information. At least for the next several years, there will be challenges with the mix of veterans in the corporate database—those paid in BDN, and those paid in VETSNET. Because the data available through the corporate database are more detailed than BDN, a one-for-one match of all data elements is not possible, and therefore in some cases, the data must be merged to provide a complete picture. VBA must continue working to accurately represent information across all data types, but until

these issues are resolved, OIG oversight of benefits processing is hampered by lack of a single comprehensive data set.

VA's Program Response to OIG Challenge #2B: Quality

ESTIMATED RESOLUTION TIMEFRAME: FY 2009

GOAL: Improve Quality of Claims Decisions and Benefits Processing **Responsible Agency Official: Director, Compensation and Pension Service**	
Completed FY 2008 Milestones	Performance Results/Impacts
Completed a **consistency review** focused on individual unemployability (IU) decisions from the Jackson, Mississippi Regional Office. Completed a **focused review** of radiation rating decisions following consolidation of radiation cases to the Jackson Regional Office. Established a **recurring special review** of cases/awards with an effective date retroactive 8 or more years or that result in a lump-sum payment of $250,000 or greater.	Identified unusual patterns of variance in decisions and allowed for better management of the compensation and pension programs' accuracy, timeliness, and consistency of decision-making for rating-related claims.
Increased the quality assurance rating review **sample size** for each of the 57 regional offices to 246 annually and **increased** Systematic Technical Accuracy Review (STAR) **staff capacity** through additional hiring.	Provides a 95 percent confidence level for each regional office. Allowed for improved quality assurance and better management of the compensation and pension programs' accuracy, timeliness, and consistency of decision-making for rating-related claims.

GOAL: Improve Quality of Claims Decisions and Benefits Processing	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Modify the rating review sample size to include **increased sampling** for initial and reopened pension claims upon completion of Phase I of pension consolidation. **(Q1)**	Allow for improved quality assurance and better management of the compensation and pension programs' accuracy, timeliness, and consistency of decision-making for rating-related claims.
Monitor and review the **quality** of rating decisions completed at a **brokered workstation** including the Resource Centers/Tiger Team. **(Q1)**	Allow for better management of the compensation and pension programs' accuracy, timeliness, and consistency of decision-making for rating-related claims and incorporate routine quality oversight of brokered cases by STAR.
Complete initial **quality reviews** of Disability Evaluation System (DES) pilot cases and develop a plan for future ongoing reviews. **(Q2)**	Use the results from the pilot project to identify any unusual patterns of variance in decisions and incorporate DES case reviews into routine quality oversight by STAR.

OIG Challenge #2C: Staffing

Congress passed legislation in 2007 and 2008 to provide VBA $185 million to hire additional claims processing staff. By the beginning of 2009, VBA expects to complete a 2-year nationwide recruiting effort to hire approximately 3,100 new staff. VBA allocated about 91 percent of the new hires to the Compensation and Pension business line and has hired over 2,400 new staff through May 2008. While such an increase in staff should eventually pay dividends, VBA faces a major challenge in training, reviewing the work of employees at developmental stages, and in controlling the quality of work to improve consistency and reduce controllable variance in disability compensation monetary benefit payments. VBA also must overcome the short-term decline in productivity in claims processing that has resulted from adding this large contingent of staff. OIG plans to monitor the effect of the recruiting through its oversight work.

VA's Program Response to OIG Challenge #2C: Staffing

ESTIMATED RESOLUTION TIMEFRAME: FY 2009

GOAL: Effectively Train and Integrate Newly Hired Staff

Responsible Agency Official: Under Secretary for Benefits

Completed FY 2008 Milestones	Performance Results/Impacts
Hired and initiated **training** for 3,456 new employees since January 2007 of which 2,980 were allocated to C&P claims processing in the field.	Improved performance in burial and dependency claims, as well as improvements in production and timeliness of rating-related claims. For example, rating productivity is up 8.7 percent from FY 2007.
Used **rehired annuitants** to assist the **Tiger Team** with processing VBA's claims from those veterans over age 70, as well as VBA's older claims.	Reduced the number of claims pending over 1 year by 33.3 percent.

GOAL: Effectively Train and Integrate Newly Hired Staff

Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Maintain FY 2008 staffing levels. **(FY 2009)**	The maintenance of staffing levels will allow VBA to **solidify gains** in performance improvement both in claims inventory and claims processing timeliness.
Continue the use of **centralized training** for new employees and the **annual 80-hour training requirement** for claims processors.	Improvement in accuracy and continued **increases** in **productivity** and **timeliness**.
Finish **training** Pension Management Center employees in preparation for completion of the consolidation of survivor benefit claims processing to the PMCs. **(Q3)**	Allow regional offices to focus on processing other disability claims.

OIG CHALLENGE #3: FINANCIAL MANAGEMENT

-Strategic Overview-

Sound financial management is not only the stewardship that makes 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 oversight assists VA in providing its program managers with timely, accurate, and reliable information for sound oversight and decision-making while identifying opportunities to improve the quality, management, and efficiency of VA's financial management systems.

OIG audit work shows no significant improvements in VA's consolidated financial statements (CFS) over the past 12 months. Although the most recent audit covering 2006–2007 again provided an unqualified or "clean" opinion, the report on internal controls identified three material weaknesses of longstanding duration and one new material weakness. VA is also not in compliance with the *Federal Financial Management Improvement Act of 1996 (FFMIA)*. This report discusses the material weakness in information technology (IT) security controls in the Information Management section (OIG Challenge #5).

OIG CHALLENGE #3A: Financial Management System Functionality

The 2007 CFS audit identified a recurring material weakness in financial system management functionality. Deficiencies in VA's legacy financial systems adversely impacted the preparation of the CFS. The large number of manual adjustment entries required at year-end to prepare the financial statements showed that the legacy systems did not adequately support reliable, timely, and consistent preparation, processing, and analysis of financial information. System limitations were identified in VA's legacy payroll and property systems, which did not readily provide information to support various financial accounts. Manual adjustments to the financial statements increase the risk of processing errors and misstatements. VA's remediation program to address this material weakness is the Financial and Logistics Integrated Technology Enterprise (FLITE), which is being developed to correct financial and logistics deficiencies throughout the Department. However, FLITE is not scheduled to be fully implemented until 2014.

VA's Program Response to OIG Challenge #3A: Financial Management System Functionality

ESTIMATED RESOLUTION TIMEFRAME: FY 2014

GOAL: Improve Financial Management System Functionality

Responsible Agency Official: Assistant Secretary for Management

Completed FY 2008 Milestones	Performance Results/Impacts
As part of the Financial Reporting Data Warehouse System (FRDWS) project, VA brought the following into production: • Data warehouse for the **Loan Guarantee Program Interface Centralized Property Tracking System** (CPTS). • Data warehouse for the **Loan Guarantee Program Interface Countrywide Home Loans** (CHL). • Data warehouse for the **Loan Guarantee Program Interface Funding Fee Payment System** (FFPS). • Data warehouse for the **VistA Account Receivable (AR) interface**. • Data warehouse for the **VistA FEE interface**.	The FRDWS and the Business Intelligence analytical tool **simplified reconciliations** of seven program interfaces with VA's core accounting system (FMS) and provided an automated process for single view of detailed data comparison with summary FMS data. This enhanced reconciliation capability helps to mitigate the Financial Management System Functionality material weakness.
As part of the FLITE project, VA did the following: • Awarded a contract to complete the **Integrated Financial Accounting System** (IFAS) financial requirements and business processes. • Released the request for proposal (RFP) for the **Strategic Asset Management** (SAM) Pilot implementation. • Released the RFP for the **FLITE Program Management Office Support** (PMOS). • Continued **change management** and **communication** activities targeted to VA stakeholders.	Completion of FLITE major milestones continued to move VA toward achieving implementation of a fully integrated, enterprise-wide financial and asset management system.
Modified Personnel and Accounting Integrated Data (PAID) to **correct programming errors** related to the Accrued Annual Leave Report.	Modifications corrected the report, which now accurately reflects annual leave hours accrued. The report is provided to the auditors and is used by VA in preparation of the consolidated financial statements.
Changed the legacy core financial system to **improve compliance** with **reporting of Taxpayer Identification Numbers** (TIN) on payments sent through the Department of the Treasury (Treasury).	Improved **accuracy** and **quality** of TIN information in payment data so that Treasury can improve identification of payments for offset.
Implemented quarterly **user access reviews**.	Enhanced **security** of system by ensuring that all users of the system and access levels have been reviewed for accuracy on a quarterly basis.

GOAL: Improve Financial Management System Functionality	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
FLITE-related work will consist of the following: • Release the draft of the **RFP for the IFAS component** of FLITE following OMB financial management line of business (FMLoB) guidance. **(Q1)** • Award the **Program Management Support Service Contract**. **(Q2)** • **Award** the **SAM Pilot** implementation **Contract**. **(Q2)** • **Initiate SAM pilot** at Milwaukee VA Medical Center to attain initial operating capability of the SAM system. **(Q2)** • **Award IFAS Implementation Contract** for Pilot Phase. **(Q4)**	The FLITE Program is continuing to address the Financial Management System Functionality material weakness by implementing an enterprise level, integrated financial and asset management system.
Begin a quarterly review of **Accrued Annual Leave Reports**. **(FY 2009 and beyond)**	Ensure accuracy of reports (including payroll adjustments) prior to request from auditors.
Begin i**ntegration** of **legacy core financial system** with the **Central Contractor Registration System**. **(Q3)**	**Vendor information** in financial system is accurate and the number of payments rejected due to inaccurate bank information is reduced.

OIG CHALLENGE #3B: Financial Management Oversight

The CFS audit also identified a material weakness in financial management oversight, which is another recurring problem in VA. Significant deficiencies in financial operations show the need for enhanced management oversight. Most of these same deficiencies have been identified in prior years, but remain uncorrected. Past approaches to correct these problems, which have included training and more management involvement, have not proven effective. Our auditors concluded that management should review the root causes and the reasons why these remedial efforts have had limited success. We found that the operational causes of the conditions included lack of resources, particularly staff with appropriate skills, and significant workload volume. The effect of recording financial data without sufficient review and monitoring by management is an increased likelihood that errors in the financial statements will occur but will not be detected.

VA's Program Response to OIG Challenge #3B: Financial Management Oversight

ESTIMATED RESOLUTION TIMEFRAME: FY 2011

GOAL: Improve Financial Management Oversight

Responsible Agency Official: Assistant Secretary for Management
Veterans Benefits Administration Chief Financial Officer
Veterans Health Administration Chief Financial Officer

Completed FY 2008 Milestones	Performance Results/Impacts
Provided oversight of field compliance with financial policies and procedures during Office of Business Oversight reviews.	Identified and reported **774** instances of **non-compliance** with policies and procedures, including root causes of conditions, and issued **552 recommendations** to correct deficiencies noted. The recommendations are tracked until implemented, thus eliminating the non-compliance issues identified at the sites visited. Additionally, summary reporting is completed at the VA Central Office level to address systemic issues identified during site reviews.
Completed OMB Circular A-123, Appendix A, review of key business processes and developed **remediation processes and plans** to correct findings.	Assessed and tested key business processes of **internal controls** over financial reporting to identify internal control weaknesses. Process owners developed remediation plans to address each newly identified weakness. Remediation plans are subject to continuous monitoring and status reporting until resolution.
Completed development and testing and will commence implementation of the **Intragovernmental Reporting System (IGRS)**. This reporting system will enhance form reporting and analysis.	Improved quality of VA data reported in the Governmentwide Financial Report.

GOAL: Improve Financial Management Oversight Responsible Agency Official: Assistant Secretary for Management Veterans Benefits Administration Chief Financial Officer Veterans Health Administration Chief Financial Officer	
Completed FY 2008 Milestones	Performance Results/Impacts
Awarded contract to assist in the development and update of the multi-year **Financial Policy Improvement Initiative (FPII)**. Established VA's **Financial Policy Steering Committee**, chaired by VA's Deputy CFO, and comprised of the chief financial officers of VA's three Administrations and selected staff offices. Issued the associated Steering Committee Charter. Established a **Financial Policy Work Group**, with members designated by the Financial Policy Steering Committee, to conduct detailed updates and reviews of all financial policies and procedures. Issued drafts of financial policies and procedures on General Accounting for review.	**Standardization** of financial management policies and procedures will improve uniformity, consistency, and accuracy, as well as compliance with all financial management laws and regulations. **New financial policies** and procedures will be drafted where none exist or are outdated, ensuring **compliance** with Federal Accounting Standards Advisory Board (FASAB) standards, OMB circulars, and U.S. Treasury financial management guidance.
Issued request for proposal for the **Audit Readiness contract** designed to assist in eliminating financial management weaknesses and deficiencies identified during the annual audits.	The multi-year **Audit Readiness** project will provide oversight and technical advice in the implementation of remediation plans designed to correct the Department's material weaknesses.
Issued a letter to all VBA stations emphasizing the need to follow the **VBA directive on reconciliations**.	VBA improved reconciliations with a proper level of review and follow-up to clear outstanding items more timely – particularly for critical accounts.
Implemented **second-level management review** of VBA financial statements using checklists and a formal review process.	VBA improved the quality and timeliness of all financial statements and reports. The second-level management review ensures financial reports are submitted on time and has reduced the number of errors in the reports prior to being released to the Department Finance staff for their review and comments.
Disseminated a **monthly reconciliation package** to be used by VHA facilities providing a uniform tool for completion of monthly reconciliations.	The package ensures that facilities are reviewing and **reconciling** their monthly **financial reports**, as well as provides VHA's CFO with a tool to monitor compliance.
Reviewed facilities' **environmental liability estimates** for propriety and necessary corrections.	Better oversight resulted in increased compliance with the Department's policies and procedures.
Provided facilities with monthly **abnormal balance reports** to enable field correction.	This process allows for timely review of the corrective actions and performance of necessary follow-up with facilities as needed.
Reviewed medical facility monthly property, plant, and equipment **reconciliation reports**.	The monthly reviews helped ensure timely capitalization.

GOAL: Improve Financial Management Oversight Responsible Agency Official: Assistant Secretary for Management Veterans Benefits Administration Chief Financial Officer Veterans Health Administration Chief Financial Officer	
Completed FY 2008 Milestones	Performance Results/Impacts
VHA's CFO provided facilities with monthly reports of **federal advances** for prior fiscal years so that facilities can offset these advances to the appropriate obligations.	This process assists in **closing out aging obligations.**
Issued a **desk guide** to serve as a quick reference on matters pertaining to the management and processing of overpayments, refunds, offsets, underpayments, and associated third party payer practices and policies that impact the VHA revenue management cycle.	This desk guide improved **accuracy** and **timeliness** in collections, reconciliations, and follow-up of health care debt.
Issued several VHA **accounting policies/procedures** dealing with: reconciliation requirements, proper capitalization of work-in-process projects, removing property that no longer belongs to VA from VA's general ledger, proper accounting for environmental liabilities (this guidance includes requirements and methodologies for estimating and recording environmental liabilities) and deferred maintenance, and accurate recording of accrued service payables. Released a comprehensive 141 page **non-healthcare debt** desk guide to the VHA field offices. Held a national non-healthcare debt conference to review and discuss the contents of the desk guide and emphasize the importance of proper management of non-healthcare debt as it relates to financial requirements and operational oversight.	Dissemination of these policies has provided field staff with a better understanding of requirements and will also support a more consistent application of accounting polices/procedures across VHA.

GOAL: Improve Financial Management Oversight	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Continue **aggressive oversight** of field compliance with financial policies and procedures through regular recurring reviews. **(Q4)** Regular review means the same audit program is executed for the same category of review for the entire fiscal year. For example, for the eight VBA Compensation and Pension reviews completed in FY 2008, the same audit program was executed. For VBA regional offices, the review cycle is approximately once every six years. For VHA Revenue and Expense reviews, a risk assessment is completed to select stations with the highest potential for non-compliance. During FY 2007 and FY 2008, a total of 35 VHA financial reviews were completed each year.	Identifying and reporting on non-compliance with policies and procedures on a regular basis will assist field managers and VA Central Office in addressing problems.
Implement OMB Circular A-123, Appendix A review program to **assess risk and test key internal controls** over financial reporting. • Complete risk assessment and annual review plan. **(Q1)** • Complete entity-level evaluation of key controls and complete update process narratives. **(Q2)** • Complete testing of key controls over financial reporting. **(Q3)** • Complete reporting of findings to SAT and incorporate into PAR. **(Q4)** **Monitor and report** remediation plan status and independent verification. **(FY 2009)**	VA's risk-based approach to testing internal controls over financial reporting will improve VA's assessment of high and medium risk controls. Additionally, this will improve VA's capability to effectively assess these controls and develop root cause remediation plans where deficiencies are identified. Management will have improved tools and information to make resource decisions, allocating resources towards monitoring riskier activities and deficiencies. Oversight is improved by focused attention on riskier processes and continuous monitoring of remediation actions.
Complete **implementation** of an IGRS. **(Q1)**	VA will improve the quality of its data reported in the Governmentwide Financial Report, and the ability to more accurately reconcile this information.

GOAL: Improve Financial Management Oversight	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Continue with the multi-year **FPII**. **(FY 2009 and beyond)** **Publish financial policies and procedures** on General Accounting; Appropriations, Funds & Related Information; Assets; Financial Reporting; and Committee on Waivers & Compromises. **(Q4)** **Issue** draft **financial policies and procedures** on Miscellaneous Accounting Topics, Liabilities, Cash Management, Debt Management, and Cost Accounting. **(Q4)**	**Standardization** of financial management policies and procedures will improve uniformity, consistency, and accuracy, as well as compliance with all financial management laws and regulations. New VA financial policies and procedures will be drafted where none exist or are outdated, ensuring compliance with FASAB standards, OMB circulars, and U.S. Treasury financial management guidance.
Continue with the multi-year **Audit Readiness initiative**. **(FY 2009 and beyond)**	VA will have better technical assistance and oversight in implementing corrective action plans designed to remediate the Department's material weaknesses.
VBA will actively participate in the Department initiative to **update** VA **finance and accounting policy and procedures**. **(FY 2009)**	The update will improve overall financial operations by providing **consistent guidance** that is in compliance with financial management laws and regulations.
VHA's CFO will work with the VA Office of Finance to develop new policy for undelivered orders/accrued services payables follow-up, first party medical-care debts and non-medical care debts follow-up, and quarterly reviews of work-in-process items. Plan a national finance conference to address the operational oversight weakness areas from a tactical standpoint for the staff performing the functions, and a strategic standpoint for management overseeing the processes.	This new policy will help ensure that projects that have been completed and placed in service are removed from work-in-process and capitalized.
Will create an **engineering** and **fiscal** workgroup to address roles and responsibilities as they relate to the financial statement audit process.	The workgroup will address policies and procedures for timely capitalization. It will also address the requirements for estimating, reviewing, and recording estimates for **environmental liabilities** and deferred maintenance to ensure they are **properly documented** and supportable.
Create a **logistic** and **fiscal** workgroup to address roles and responsibilities as they relate to the financial statement audit process.	The workgroup will address procedures for ensuring that relevant documentation is properly maintained in order to provide an appropriate **audit trail** for procurement activities. The workgroup will also establish coordination of contract changes between the two offices to ensure that appropriate and timely updates are made in the financial management system.

OIG CHALLENGE #3C: Benefits Delivery Network System Records

The CFS audit identified a new material weakness involving the retention of computer-generated records kept in VBA's BDN system. Because transaction detail records are kept in BDN for only 60 to 90 days, management was unable to support certain dollar amounts recorded in the CFS. The audit also found large disparities between the amounts shown in the BDN subsidiary ledger and the Financial Management System general ledger for the compensation, pension, and education programs. The differences were attributed to BDN system limitations and the high volume of transactions processed daily. VA needs to develop and implement policies and procedures to ensure that computer generated transaction details are retained for appropriate time periods to adequately support an audit trail for the balances recorded in the CFS.

VA's Program Response to OIG Challenge #3C: Benefits Delivery Network System Records

ESTIMATED RESOLUTION TIMEFRAME: COMPLETED

The FY 2008 financial audit, performed by Deloitte and Touche, concluded that this challenge was resolved/remediated. The FY 2008 milestones shown below reflect the actions VA took to resolve this challenge.

GOAL: Retain BDN Records for Appropriate Time Periods to Adequately Support an Audit Trail For Balances Recorded in the CFS

Responsible Agency Official: Veterans Benefits Administration Chief Financial Officer
Assistant Secretary for Information and Technology

Completed FY 2008 Milestones	Performance Results/Impacts
Validated the existence of **reconcilable** Compensation and Pension (C&P) **transaction data** in BDN. Identified nine BDN-generated files with FY 2008 C&P **transaction details** and retained the files until they could be transmitted to the **VBA data warehouse**. **Built business rules** that would enable the reconciliation and reports generation.	VA began the process of capturing and providing reconcilable **transaction details** to support an **audit trail** for balances recorded in the consolidated financial statements.

GOAL: Retain BDN Records for Appropriate Time Periods to Adequately Support an Audit Trail For Balances Recorded in the CFS Responsible Agency Official: Veterans Benefits Administration Chief Financial Officer Assistant Secretary for Information and Technology	
Completed FY 2008 Milestones	Performance Results/Impacts
Analyzed and determined the **capacity required** to support the Audit Trail solution in the data warehouse. **Identified** Education and VR&E BDN **data files** to support the Audit Trail solution. Developed a **two-phased project schedule**—an interim, short-term manual solution, and a long-term automated solution. Analyzed and validated **Corporate database** to validate existence of reconcilable transaction data. Delivered **monthly reconcilable detail transaction C&P data** for the months of March through September to OIG auditors.	The Audit Trail solution is being implemented in two phases. Phase I is being implemented and is scoped to meet FY 2008 audit requirements. Phase I pulls detailed transaction extracts from the BDN and the VBA Corporate Database and loads them into the VBA Data Warehouse. The transaction data are then reconciled against the General Ledger. Phase II will provide additional reporting capability for VA.
Began same process as above for **Education Chapter 30** detail data.	VA began the process of capturing reconcilable detailed Education data to support an audit trail for balances recorded in the 2009 consolidated financial statements.

OIG CHALLENGE #4: PROCUREMENT PRACTICES

-Strategic Overview-

OIG continues to identify significant and persistent deficiencies in VA procurement practices. VA, one of the largest procurement and supply agencies in the Federal government, expends about $10 billion annually on supplies and services. Our audits, investigations, and reviews have identified consistent deficiencies in the planning, solicitation, award and administration of contracts, and purchasing practices. Because procurement activities are decentralized and VA does not have adequate information systems that accurately capture contracting and purchasing data, VA has little oversight of its procurement and purchasing activities. VA does not know what it buys, who it buys it from, whether the price paid was fair and reasonable, or whether contracting entities complied with procurement laws and regulations. Although VA mandated in June 2007 the use of a new electronic contract management system to track all contract actions, this system currently is unreliable and incomplete. In summary, we have seen little progress in improving procurement practices over the past 12 months.

OIG CHALLENGE #4A: Open Market Procurements and Inventory Controls

Our audit of the acquisition and management of selected surgical device implants (SDI) found that VA needs to reduce procurement costs and strengthen management controls over inventory, patient privacy, and device recalls. Costs could be reduced by as much as $21.7 million over 5 years by using national contracts and blanket purchase orders instead of open market purchases. OIG's review of procurement practices also revealed that VHA needs to improve inventory controls and strengthen patient safeguards. Facilities lacked reliable inventory controls and records, staff routinely provided manufacturers more medical and personal information than needed, and the staff needed to ensure that patients affected by SDI recalls received timely follow-up care.

VA's Program Response to OIG Challenge #4A: Open Market Procurements and Inventory Controls

ESTIMATED RESOLUTION TIMEFRAME: FY 2009 AND BEYOND

GOAL: Reduce Procurement Costs and Strengthen Management Controls

Responsible Agency Official: Principal Deputy Under Secretary for Health

Completed FY 2008 Milestones	Performance Results/Impacts
VA's Office of Business Oversight conducted a Veterans Integrated Service Network (VISN)-wide **contract inspection** to continue **oversight of field compliance** with Federal and VA acquisition policies and to strengthen VISN management controls over the **acquisition** function. Conducted a contract inspection and comprehensive internal control review of the acquisition function for the VA Boston HealthCare System.	The inspection identified areas of non-compliance with rules and regulations and provided local management with recommendations for **corrective actions** to improve their **acquisition** activities. Managers at both the field station and VISN level are correcting deficiencies in acquisition internal controls and will be able to prevent future recurrence of non-compliance.
Conducted **logistics business reviews** at 14 individual stations and reviewed non-expendable inventory management at 37 individual stations across 4 VISNs.	The reviews identified areas of non-compliance with rules and regulations and provided local management with recommendations for **corrective actions** to improve their **logistics** activities. Managers at both the field station and VISN level are correcting deficiencies in acquisition internal controls and will be able to prevent future recurrence of non-compliance.
Established workgroup to review and create **contract specifications** for the bare metal and drug-eluting coronary stents.	Establishment of national contracts increases **cost savings.**
Began the process of **standardizing surgical devices** such as Pacemakers, ICDs, Leads. Monitored the procurement, serial number tracking, and utilization on a quarterly basis via the National Prosthetic Patient Database (NPPD).	Standardization has increased **compliance** with documentation and tracking of serial numbers for recall purposes.

GOAL: Reduce Procurement Costs and Strengthen Management Controls Responsible Agency Official: Principal Deputy Under Secretary for Health	
Completed FY 2008 Milestones	Performance Results/Impacts
Developed policy for tracking of **inventory** and monitoring of **stock levels** and reminded staff of their responsibilities in relation to the surgical implant inventory.	VA has increased staff awareness of the importance of proper inventory control.
Established a task force to create a directive with standardized procedures on how inventory of implants will be accomplished.	The directive, which is in concurrence, will provide guidance to the field on the proper procedures for managing SDI in an inventory account, as well as the proper medical and personal information to be released to the vendor for ordering purposes.
Developing a database of surgical implants that will help track when a recall is issued so that correct action can be taken to recall the product.	The SDI tracking database will enable timely notification of individuals affected by recalls.
Through Project HERO, utilized competitive health care market contracts priced on a Medicare scale. Project HERO pricing is, on average, at or below Medicare rates. Project HERO pricing is also continuously monitored by the Contracting Officers.	Monitoring ensures that the pricing for services remains competitive and appropriate.

GOAL: Reduce Procurement Costs and Strengthen Management Controls	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Continue **aggressive oversight** of field compliance with acquisition and logistics policies and procedures as part of FY 2009 Annual Review Plan. **(Q4)**	Oversight programs in areas such as contract inspections and logistics business reviews to identify areas of non-compliance with rules and regulations provide field and Central Office managers with information to correct deficiencies in internal controls and prevent future recurrence of non-compliance.
Continue working on policy for tracking of inventory and monitoring of stock levels. **(Q2)**	VA will improve inventory management and tracking of implants for budget and recall purposes.
Begin Rewrite of VA Directive 1663, Health Care Resources Contracting - Buying. **(Q2)**	The directive will be revised to provide better direction.
Will process all selling and buying enhanced-sharing agreements through the electronic contract management system (eCMS). **(Q3)**	eCMS will significantly improve the standardization of sharing agreement contract format and will enable more accurate data record keeping.
Continue to develop contract specifications for surgical implants such as bare metal and drug-eluting coronary stents. **(Q4)**	The specifications will reduce lost savings from open market purchases.
Reengineer the Standardization Program to provide better operational efficiencies. **(Q4)**	Reengineering will increase utilization of resources and improve overall quality of the medical supply chain system.

OIG CHALLENGE #4B: Contract Modifications to Use Expired Years Funds

OIG has identified impermissible use of contract modifications to expend expired prior-year funds. A 2007 OIG audit found that improper contract modifications resulted in the unlawful use of expired prior-year funds by the VA Boston Healthcare System. The modifications valued at approximately $5.4 million were not within the scope of the original contracts, not funded in accordance with appropriations law, and not in compliance with actions outlined in the Federal Acquisition Regulation (FAR).

In 2008, we conducted a national audit to review the effectiveness of VHA controls over the use of prior-year funds for maintenance. Consistent with the findings in the VA Boston Healthcare System, we found out-of-scope modifications to contracts that resulted in the unlawful use of prior-year appropriations. Controls need strengthening to ensure that: (1) contract changes are within the scope of the original contracts, (2) facilities obtain proper approval to use prior-year funds, and (3) funding for contract changes is in accordance with appropriations law and the FAR. For example, there are no controls above the contracting officer level to review contract modifications to ensure they are within the scope of the original contract. Oversight over contracting officials' activities needs to be increased to improve the accountability of their actions.

VA's Program Response to OIG Challenge #4B: Contract Modifications to Use Expired Years Funds

ESTIMATED RESOLUTION TIMEFRAME: FY 2009 AND BEYOND

GOAL: Strengthen Controls Over Contract Modifications

Responsible Agency Official: Veterans Health Administration Chief Prosthetics, Procurement and Logistics Officer

Completed FY 2008 Milestones	Performance Results/Impacts
Conducted a **review of expired fund obligations** for compliance with federal appropriations law for VISN 1, VA New England Healthcare System.	VA identified reasons for using expired funds and determined whether the increases complied with federal appropriations law. The review also determined whether contract changes were within the scope of the original contracts. The report recommended VISN management make accounting adjustments by moving obligations and expenses to the correct appropriation year. In addition, the review verified that accounting adjustments were in fact made when non-compliance with appropriations law was identified.
Conducted a VISN-wide **contract inspection** to continue **oversight of field compliance** with federal and Departmental acquisition policies and to strengthen VISN management controls over the acquisition function. In addition, conducted a contract inspection and comprehensive internal control review of the acquisition function for the VA Boston HealthCare System.	The inspection identified areas of non-compliance with rules and regulations and provided local management with recommendations for corrective actions to improve their acquisition activities. Managers at both the field station and VISN level are in a better position to correct deficiencies in acquisition internal controls and prevent future recurrence of non-compliance.

GOAL: Strengthen Controls Over Contract Modifications	
Responsible Agency Official: Veterans Health Administration Chief Prosthetics, Procurement and Logistics Officer	
Completed FY 2008 Milestones	Performance Results/Impacts
Conducted VHA **Contract Readiness Exercise** for procurements $500,000 and greater.	Areas needing training were identified.
Developed an **expired funding** reporting mechanism.	VHA identified and corrected the use of expired funding.
Implemented VA Directive 4533 on **Miscellaneous Obligation** (VA Form 1358), which prohibits using this category for obligating construction funds.	This will benefit VA by requiring supplies/services to be procured using a purchase request, which must be reviewed by contracting staff. This additional review will improve the integrity of the procurement system as purchase requests are monitored and tracked by acquisition staff, as well as reviewed by fiscal staff.
Revised and issued VHA Directive 2008-019, to provide and **clarify requirements** pertaining to use of **prior-year (PY) funds** for non-recurring maintenance (NRM) projects.	Requests for use of PY funds have increased, indicating that **facilities** have a **better understanding** of approval requirements and compliance has improved. Approved requests for use of PY funds are compared to PY increases in NRM obligations and reconciled quarterly. Reconciliation results are assessed and variances resolved.

GOAL: Strengthen Controls Over Contract Modifications	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Provide **oversight on VA's compliance** with federal appropriations law through a Department-wide review of expired fund obligations. **(Q2)**	VA will identify whether non-compliance is systemic across the Department and whether scope modifications to contracts resulted in the unlawful use of prior-year appropriations. If necessary, the review will include recommendations to improve internal controls over expired fund obligations and contract scope modifications.
Continue **aggressive oversight** of field compliance with **acquisition** policies and procedures as part of FY 2009 Annual Review Plan. **(Q4)**	Identifying and reporting on non-compliance with policies and procedures will assist field managers and VA Central Office to correct any deficiencies in internal controls and prevent future recurrence of non-compliance.
Revise the NRM Projects Handbook. **(Q1)** Continue to provide capital asset training for the Engineers and Capital Asset Managers on appropriate scope changes for NRM projects. **(FY 2009 and beyond)**	The Handbook will further clarify the scope changes, requirements, and funding processes for NRMs.

GOAL: Strengthen Controls Over Contract Modifications	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Continue on-going reconciliation of approved requests to use PY funds compared to obligation increases recorded in the financial system for NRM projects. **(FY 2009 and beyond)**	VA will continue to improve compliance with the use of PY funds approval requirements.
VHA's Office of Finance will consult with the Assistant Secretary for Management to develop plans to implement broader controls and requirements for use of prior-year funds for contract changes.	Compliance with 38 USC 1552.

OIG CHALLENGE #4C: Contract Award and Administration

OIG review of Federal Supply Schedule contracts that VA awarded to resellers without significant commercial sales revealed that contracting officers were not taking appropriate action to determine price reasonableness at the time of award or when allowing price increases. Contracting officers also did not identify appropriate tracking customers to ensure that the Government's prices remained fair and reasonable after award.

Our review of a contract awarded by the Office of Information and Technology to standardize VA's desktop computers showed deficiencies in the planning, award, and administration of the contract. The contract specifications were overly restrictive and, when bundled with installation services, limited competition. In addition, the price evaluation was not done properly, which resulted in the more expensive decision to lease rather than purchase the computers. Although the first order against the contract was placed in September 2007, by February 2008, the vast majority of computers had not been delivered because VA had not developed the standard image that was required to be installed by the vendor prior to delivery.

An audit of VHA's non-competitively awarded contracts for health care services identified the need to improve contract administration and monitoring. For example, the lack of contract monitoring at VAMC Miami was a contributing factor in the VAMC paying about $2.2 million for 2007 services it did not receive. Because the contract did not provide for adjustments of payments without contract modifications, the payments are not recoverable. We also found that the database used to analyze the number of current clinical service contracts is unreliable because the VISNs have not been submitting information on all of their contracts. Therefore, VA does not know how many contracts are in place, what services are being provided, by whom, or what VA is paying for those services.

Our review of a contract awarded in 2003 for rating examinations revealed that VA had not reviewed the procedural codes submitted by the vendor to ensure that the codes were proper Medicare Current Procedural Terminology (CPT) codes as required under the contract. In addition, VA did not request or calculate the agreed upon prices for each CPT code. As a result, VA overpaid $6.2 million.

VA's Program Response to OIG Challenge #4C: Contract Award and Administration

ESTIMATED RESOLUTION TIMEFRAME: FY 2009

GOAL: Improve Contract Award and Administration Processes

Responsible Agency Official: Deputy Assistant Secretary for Acquisition and Logistics (OA&L); Assistant Secretary for Information and Technology
Veterans Health Administration Chief Prosthetics, Procurement and Logistics Officer

Completed FY 2008 Milestones	Performance Results/Impacts
In response to the OIG's report on resellers, established a workgroup to develop a course of action for each recommendation. The General Services Administration may issue new policies based on the workgroup's findings.	Clearer procedures, processes, and training have been provided to contracting staff.
Implemented the following process improvements and actions: • Implemented **Contract Review Boards** (CRBs) within OA&L. Plans are in place to implement CRBs throughout VA starting in November of 2008. An **Integrated Product Team** (IPT) policy has been implemented agency-wide. • Finalized the **VA Acquisition Regulation (VAAR) rewrite**. • Supported the funding for **additional contract attorneys** to oversee field contracts.	Use of CRBs and IPTs has resulted in the successful award of major contracts.
Conducted a VISN-wide **contract inspection** to continue **oversight of field compliance** with federal and Departmental acquisition policies and to strengthen VISN management controls over the acquisition function. In addition, conducted a contract inspection and comprehensive internal control review of the acquisition function for the VA Boston HealthCare System.	The inspection identified areas of non-compliance with rules and regulations and provided local management with recommendations for corrective actions to improve their acquisition activities. Managers at both the field station and VISN level are in a better position to correct deficiencies in acquisition internal controls and prevent future recurrence of non-compliance.
Worked with Austin Information Technology Acquisition Center to develop plan that improves the quality of procurement packages.	Procurement packages submitted to VA's IT contracting office have required significantly fewer modifications, resulting in shorter turnaround times and ultimately faster award of contracts.
Trained staff using internal resources and the Defense Acquisition University to help individuals understand the latest Federal Acquisition Regulation and changes to VA Acquisition Regulation.	Staff performance has markedly improved as a result of the training and has enabled those trained to mentor others. This increased knowledge reduces acquisition timelines.

GOAL: Improve Contract Award and Administration Processes Responsible Agency Official: Deputy Assistant Secretary for Acquisition and Logistics (OA&L); Assistant Secretary for Information and Technology Veterans Health Administration Chief Prosthetics, Procurement and Logistics Officer	
Completed FY 2008 Milestones	Performance Results/Impacts
Developed the VHA **Contracting Officer Technical Representative (COTR) training plan** and program.	The training plan has improved contract administration and monitoring of performance, and ensured that Networks have guidelines to follow to meet the COTR certification requirements mandated by the Office of Management and Budget.
VHA developed the **Purchase Card Program Directive and Handbook**.	New policies and procedures have improved the effectiveness/efficiency of the purchase card program in VHA and improved oversight functions. Each Network has hired or is hiring a purchase card manager who is responsible for ensuring compliance with the role, responsibilities, and oversight functions identified by the VHA Directive and Handbook.
Conducted oversight of the VHA **contract readiness** Phase II of the oversight work – assessed action plans to address weaknesses identified in the review.	Oversight has improved contract administration and identified training needs. The readiness exercise allowed Networks to identify deficiencies and develop action plans to resolve them.
Published procurement and contracting **Standard Operating Procedures (SOPs)**.	SOPs have improved the award and administration process. Networks are able to use SOPs to support VA efforts to standardize contracting processes and procedures.
Developed the **Federal Procurement Data System (FPDS) Verification/Validation Process**.	The new process has improved FPDS reporting and annual certification process. Standardized certification language was developed that details what is excluded from the FPDS reporting requirement. This is a significant improvement because previously the certification did not expressly state what was excluded, which is the reason some Networks did not certify the data.
Develop a standardized process and statement of work (SOW) for **Interior Design** projects.	VA has improved the Interior Design award and administration process. Communication between the acquisition and the interior design staff has improved. Acquisition staff attended an interior design conference to discuss how acquisition regulations impact interior design procurements.
Through **Project HERO**, VA administered a well-organized and planned Request for Proposal process, including the use of an active Integrated Product Team for Project HERO contracts.	Evaluation of competitive proposals resulted in awarding contracts to the most deserving bidders. The process ensures that contractors continue to comply with contract requirements or are appropriately disciplined in instances of non-compliance.

GOAL: Improve Contract Award and Administration Processes	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Implement any GSA policy changes related to the multiple award schedules (MAS) program, particularly related to **resellers, pricing, and tracking customers**. **(Q1)**	If GSA issues no new policies as a result of VA's workgroup findings, the impacts will be minimal. Should GSA issue major policy changes as the result of the above, VA expects significant impact as more than 1,800 current contracts will require modification/ renegotiation.
Bring **contract attorneys on board** in all VISNs. **(Q1)** Put in place a new process for **disseminating acquisition policy**. **(Q1)**	With the addition of contract attorneys in all VISNs, VA will be able to **fully implement** CRBs and IPTs and be represented if there is a protest of a claim filed. VA acquisition policy will be developed and communicated to the field more efficiently and effectively.
Continue **aggressive oversight** of field compliance with **acquisition** policies and procedures as part of FY 2009 Annual Review Plan. **(Q4)**	Identifying and reporting on non-compliance with policies and procedures will assist field managers and VA Central Office to correct any deficiencies in internal controls and prevent future recurrence of non-compliance.
Continue staff training initiatives, focusing not only on mandatory certifications, but on classes that share best practices.	Better understanding of acquisition regulations should improve overall performance and success rate of meeting customer expectations in the shortest timeframe possible.
Work to obtain specific customer needs in a timelier manner, particularly identifying source and timing of funds to accomplish procurements.	Having projects in hand backed up with earmarked funds will allow procurements to start earlier, which should result in earlier completions.

GOAL: Improve Contract Award and Administration Processes	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
VA will accomplish the following: • Conduct oversight of VHA **contract readiness** Phase III. **(Q1)** • Develop **Lease Training Program. (Q1)** • Develop the **Construction Multiple Award** Task Order Contract for VHA. **(Q1)** • Develop the Construction and A&E standard operating procedures. **(Q1)** • Develop training program for non-procurement personnel. **(Q1)** • Develop **Purchase Card Training** Program. **(Q2)** • **Contracting Officer Technical Representative (COTR) training** is available online using the VA Learning Management System (LMS). COTRs are required to meet the certification requirements established by VA Information Letter, 049-08-02. Training in specific specialties is not addressed, as these courses are taken by the individual based on their specialty, for example, construction. Additionally, acquisition staff select specialty training to complete the continuing education courses. The reason that specialty "lease training" is addressed is to ensure the recent GSA lease requirement training is available.	These actions will improve contract administration and identify training needs.

OIG CHALLENGE #4D: Electronic Contract Management System

In June 2007, VA instituted the Electronic Contract Management System as VA's standard procurement system to track contracting actions. The system cost VA $18 million. An audit conducted in 2008 determined that the system is unreliable because contracting entities were not recording procurement actions and/or not recording actions accurately in the system as required by VA policy. VA procurement staff told us that they circumvented the system because it was slow and cumbersome to use. We also found that VA management was not using reports generated by the system for decision-making and/or to improve procurement processes. Although the system is a start toward compiling comprehensive information and properly controlling procurement actions at Central Office and field activities, until and unless the information entered into the system is accurate and complete, the system will be of little value to VA in managing its procurements.

VA's Program Response to OIG Challenge #4D: Electronic Contract Management System

ESTIMATED RESOLUTION TIMEFRAME: FY 2009

GOAL: Improve Reliability and Increase Utility of the Electronic Contract Management System (eCMS)

Responsible Agency Official: Deputy Assistant Secretary for Acquisition and Logistics (OA&L)
Assistant Secretary for Information and Technology
Veterans Health Administration Chief Prosthetics, Procurement and Logistics Officer

Completed FY 2008 Milestones	Performance Results/Impacts
The proposed audit report referenced in the synopsis above is pending release. Until the report is released, VA is not able to establish any corrective action plan or milestones.	Unable to address in the absence of a published report.
VA's Office of Business Oversight conducted a contract inspection and internal control review of the acquisition function for the VA Boston HealthCare System.	The review identified areas of non-compliance with rules and regulations including whether procurement actions were recorded in eCMS. The report provided local management and VISN management with recommendations for corrective actions to improve their acquisition activities including the establishment of policies and procedures for entering procurement actions in eCMS and monitoring procedures to ensure procurement documents are populated in the eCMS briefcase. This assisted managers at both the field station and VISN levels to correct deficiencies in acquisition internal controls and prevent future recurrence of non-compliance.
Conducted VHA Contract Readiness Exercise for procurements valued at $500,000 and greater.	Identified contract file weaknesses and focused training requirements.
Implemented a data warehouse report that is automatically forwarded via e-mail to the eCMS Application Coordinators on a weekly basis. **(Q4)**	Provides visibility on an ongoing basis to the data being entered by the users.

GOAL: Improve Reliability and Increase Utility of the Electronic Contract Management System

Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Establish a single point of **management responsibility** for eCMS with the Director for Acquisition Policy. **(Q4)**	Enterprise-wide responsibility for configuration control and compliance will rest with a senior manager at the Central Office level.
Hire a GS-14 **program manager** to report to Director for Acquisition Policy. **(Q4)**	The manager will provide **day-to-day responsibility** for all aspects of eCMS operations and compliance.

GOAL: Improve Reliability and Increase Utility of the Electronic Contract Management System	
Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Purchase modules within eCMS to enhance the following two features: 1. **Reporting capability (Q4)** 2. **Decision logic** to ensure that contracting officers enter key data before moving to the next screen within the system. **(Q4)**	1. Will allow for a deeper analysis of data and the production of more informative reports. The current reporting module is rudimentary and somewhat cumbersome. Coupled with enhanced oversight at the Central Office level, better reporting capability will help to identify which offices are not complying with policy. 2. This change will force contracting officers to comply with data entry policies which, in turn, will improve the **quality** and **completeness** of contract-related information.
Establish **compliance metrics** in the **performance plans of all senior procurement managers**. **(Q4)**	This change will hold local managers **accountable** for complying with data entry policies.
Continue **aggressive oversight** of field compliance with **acquisition** policies and procedures as part of FY 2009 Annual Review Plan. **(Q4)**	Identifying and reporting on non-compliance with policies and procedures will assist field managers and VA Central Office in correcting any deficiencies in internal controls and prevent future recurrence of non-compliance.
Conduct oversight of VHA contract readiness Phase III. **(Q1)**	Improves contract administration and identifies training needs.
In coordination with the stakeholders, identify the data fields that are deemed mandatory and enforce edit checks on the values entered into those fields. **(Q1)** Pursue implementation of a Business Intelligence tool to enable in-depth reporting and analysis of the data entered into the mandatory fields. **(Q4)**	These enhancements will force user entry of the information deemed essential by the stakeholders for reporting and oversight purposes.

OIG CHALLENGE #5: INFORMATION MANAGEMENT

-Strategic Overview-

VA has consolidated the vast majority of its IT resources under the Chief Information Officer (CIO), including a reorganization of functions from the VA Administrations to the Office of Information and Technology (OI&T). In 2007, the CIO issued policy and procedural guidance to assist VA in implementing an effective information security program. In addition, VA data centers and selected program offices have taken actions to remediate security control weaknesses reported in OIG audits. While improvements have been made in information governance, annual CFS and information security program audits continue to report IT security control deficiencies, which place sensitive information at risk of unauthorized use and disclosure. OIG reports show that additional actions need to be taken to safeguard and effectively manage VA's information resources and data. VA also needs to better plan and manage its IT capital investments. For these reasons, OIG must report that VA has made no progress toward eliminating the material weakness in IT security controls and little progress in remediating the major deficiencies in IT security. The Assistant Secretary for Information and Technology has acknowledged in recent testimony that the work is far from complete and much work remains, especially in the area of data security and privacy and infrastructure improvements.

OIG CHALLENGE #5A: IT Security Controls

For several years, OIG's CFS audits have identified IT security controls as a material weakness. Legacy IT infrastructure and longstanding control weaknesses continue to place financial information and veterans' medical and benefits information at risk of unauthorized use and disclosure. VA needs to improve the Department-wide security program, access control, segregation of duties, service continuity, and change control. We recommended that Department senior leadership take a VA-wide approach to implement information security programs in accordance with the standards established by the National Institute of Standards (NIST) and Office of Management and Budget (OMB), and take additional actions to better manage information security and implement effective controls over systems and applications.

VA's Program Response to OIG Challenge #5A: IT Security Controls

ESTIMATED RESOLUTION TIMEFRAME: FY 2013

GOAL: Improve IT Security Controls

Responsible Agency Official: Assistant Secretary for Information and Technology

Completed FY 2008 Milestones	Performance Results/Impacts
Established the **Data Security & Assessment & Strengthening of Controls Program** to facilitate the implementation of VA program security control program and procedures.	Facilitates the **tracking** and **resolution** of longstanding GAO and OIG deficiencies.
Conducted independent assessments of IT controls at VA facilities nationwide to facilitate centralized enforcement of IT security controls.	The assessments improved ways to monitor and enforce **compliance** with existing **laws** and **regulations** regarding IT security.

GOAL: Improve IT Security Controls

Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Implement remote access two factor authentication. Two factor authentication uses two forms of authentication to validate the identity of the user. At VA, users will enter their first form of authentication, their user ID and password, and then enter a second form of authentication, usually a token or SMART card, to validate their identity. **(Q1/2013)**	This authentication will improve controls over access to VA information and systems by helping ensure that personnel who access the VA network remotely are authorized users.
Implement Enterprise Wide Configuration Management. **(Q1/2011)**	Ensure changes to VA systems are adequately controlled to prevent the unauthorized compromise of VA information and systems.

OIG CHALLENGE #5B: Information Security Program

OIG continues to identify major IT security deficiencies in the annual information security program audits. The 2007 audit found that VA has made limited progress in complying with the Federal Information Security Management Act (FISMA) and other IT requirements imposed by NIST and OMB. Although the consolidation of IT functions and activities under the CIO has addressed some security issues, VA does not fully comply with FISMA. To achieve FISMA compliance, VA needs to: (1) complete the IT reorganization by establishing clear lines of authority; (2) develop comprehensive policies and procedures for consistent implementation of information security controls; (3) closely monitor the implementation of controls; (4) address roles and responsibilities for monitoring and enforcing controls; (5) address security control weaknesses identified in prior OIG reports; and (6) implement a rigorous certification and accreditation program.

VA's Program Response to OIG Challenge #5B: Information Security Program

ESTIMATED RESOLUTION TIMEFRAME: FY 2013

GOAL: Strengthen the Information Security Program Including Compliance with FISMA

Responsible Agency Official: Assistant Secretary for Information and Technology

Completed FY 2008 Milestones	Performance Results/Impacts
Developed **security control** policies and procedures for the Department-wide information security program.	The policies and procedures improve the protection of VA IT assets by establishing and/or strengthening controls associated with access to and accountability for VA information and systems.
Certified and accredited more than 600 Department information systems.	Reduced the **risk of compromise** to VA information and systems and allowed senior officials to better understand and manage the risks associated with the operation of VA information systems.

GOAL: Strengthen the Information Security Program Including Compliance with FISMA

Planned FY 2009 Milestones (Estimated Completion Quarter)	Anticipated Impacts
Establish a task force to enforce proper **segregation of duties** associated with access to financial information systems. **(Q1/2013)**	Will strengthen **access controls** to VA information and systems by limiting access to only authorized personnel with a valid need.
Install **Intrusion Prevention** devices. **(Q1/2009)**	The devices will strengthen access controls by **detecting** and **blocking** unauthorized attempts to access VA information and systems.

APPENDIX

The Appendix lists selected reports pertinent to the five key challenges discussed. However, the Appendix is not intended to encompass all OIG work in an area. For further information, please see the OIG home page: http://www.va.gov/oig/

HEALTH CARE DELIVERY

Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3, Report No. 07-03505-129, May 19, 2008.

Healthcare Inspection, Quality of Care Issues VA Medical Center, Marion, Illinois, Report No. 07-03386-65, January 28, 2008.

Healthcare Inspection, Additional Quality of Care Issues Marion VA Medical Center Marion, Illinois, Report No. 08-00869-102, March 26, 2008.

Healthcare Inspection, Alleged Mismanagement and Patient Care Issues Martinsburg VA Medical Center Martinsburg, West Virginia, Report No. 07-02388-68, January 31, 2008.

Healthcare Inspection, Alleged Quality of Care Issues Martinsburg VA Medical Center Martinsburg, West Virginia, Report No. 07-03087-75, February 14, 2008.

Statement of Dr. John D. Daigh Jr., M.D., Assistant Inspector General for Healthcare Inspections, Office of Inspector General, Department of Veterans Affairs, Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, on Quality of Care Issues at W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina, April 19, 2007.

Healthcare Inspection, Follow-Up Evaluation of the W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina, Report No. 07-01796-181, August 2, 2007.

Audit of the Veterans Health Administration's Home Respiratory Care Program, Report No. 06-00801-30, November 28, 2007.

Healthcare Inspection, Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program, Report No. 05-00266-39, December 13, 2007.

Statement of Michael Shepherd, M.D., Physician, Office of Healthcare Inspections, Office of Inspector General, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, United States House of Representatives, Hearing on Stopping Suicides: Mental Health Challenges within the Department of Veterans Affairs, December 12, 2007.

Statement of Jon A. Wooditch, Deputy Inspector General, Office of Inspector General, Department of Veterans Affairs, Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, Hearing on the FY 2009 Budget for the Office of Inspector General, February 13, 2008.

Follow-Up Healthcare Inspection, VA's Role in Ensuring Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation; Report No. 08-01023-119, May 1, 2008.

Healthcare Inspection, Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention, Report No. 06-03706-126, May 10, 2007.

Healthcare Inspection, Review of the Care and Death of a Veteran Patient VA Medical Centers St. Cloud and Minneapolis, Minnesota, Report No. 07-01349-127, May 10, 2007.

Healthcare Inspection, Quality of Polytrauma Care, Environmental, and Safety Issues Minneapolis VA Medical Center Minneapolis, Minnesota, Report No. 06-03671-120, April 25, 2007.

Healthcare Inspection, Alleged Premature Discharge of a Veteran VA Pittsburgh Healthcare System Pittsburgh, Pennsylvania, Report No. 07-01622-62, January 27, 2008.

Healthcare Inspection, Patient Suicide VA Medical Center Augusta, Georgia, Report No. 07-00561-167, July 11, 2007.

Statement of the Honorable George J. Opfer, Inspector General, Office of Inspector General, Department of Veterans Affairs, Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, Hearing on the Oversight Efforts of the VA Office of Inspector General: Issues, Problems, and Best Practices at the Department of Veterans Affairs, February 15, 2007.

Statement of John D. Daigh, Jr., M.D., CPA, Assistant Inspector General for Healthcare Inspections, Office of Inspector General, Department of Veterans Affairs before Committee on Veterans' Affairs, United States House of Representatives Hearing on "Why does the VA continue to give suicide-inducing drug to veterans with PTSD," July 9, 2008.

Healthcare Inspection, Comparison of VA and University Affiliated IRB Compliance with VHA Handbook 1200.5, Report No. 06-00980-217, September 28, 2007.

Administrative Investigation Loss of VA Information VA Medical Center Birmingham, AL, Report No. 07-01083-157, June 29, 2007.

Healthcare Inspection, Research Practices at Carl T. Hayden VA Medical Center Phoenix, Arizona, Report No. 07-00589-118, April 20, 2007.

Healthcare Inspection, Alleged Practice of Medicine by Unlicensed Research Assistants South Texas Veterans Health Care System, San Antonio, Texas, Report No. 07-01219-194, August 29, 2007.

Healthcare Inspection, Importation of Blood Products for Research Purposes New Mexico VA Health Care System Albuquerque, New Mexico, Report No. 07-03025-32, November 30, 2007.

Healthcare Inspection, Scopes of Practice for Unlicensed Physicians Engaged in Veterans Health Administration Research, Report No. 07-01202-124, May 7, 2008.

Healthcare Inspection, Human Subjects Protection Violations at the Central Arkansas Veterans Healthcare System, Little Rock, Arkansas, Report No. 07-03042-182, August 6, 2008.

Healthcare Inspection, Human Subjects Protection in One Research Protocol, *VA Medical Center, Washington, District of Columbia*, Report No. 08-02346-191, August 28, 2008.

Audit of Veterans Health Administration's Oversight of Nonprofit Research and Education Corporations, Report No. 07-00564-121, May 5, 2008.

BENEFITS PROCESSING

Statement of the Honorable James B. Peake, M.D., Secretary of Veterans Affairs, Before the Senate Committee on Veterans' Affairs, February 12, 2008.

Audit of the Effectiveness of Veterans Benefits Administration Compensation Writeouts, Report No. 06-01791-45, December 19, 2007.

Audit of Veterans Benefits Administration Non-Rating Claims Processing, Report No. 06-03537-69, February 7, 2008.

Statement of Mr. Jon A. Wooditch, Deputy Inspector General, Department of Veterans Affairs before the Subcommittee on Oversight and Investigations Committee on Veterans' Affairs, United States House of Representatives Hearing on Disability Claims Ratings and Benefits Disparities within the Veterans Benefits Administration, October 16, 2007.

Audit of the Impact of the Veterans Benefits Administration's Hiring Initiative, Report No. 08-01559-193, September 5, 2008.

FINANCIAL MANAGEMENT

Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2007 and 2006, Report No. 07-01016-21, November 15, 2007.

PROCUREMENT PRACTICES

Audit of the Acquisition and Management of Selected Surgical Device Implants, Report No. 06-03677-221, September 28, 2007.

Audit of Procurements Using Prior-Year Funds to Maintain VA Healthcare Facilities, Report No. 08-00244-213, September 30, 2008.

Audit of VHA Noncompetitive Clinical Sharing Agreements, Report No. 08-00477-211, September 29, 2008.

Final Report, Special Review of Federal Supply Schedule Medical Equipment and Supply Contracts Awarded to Resellers, Report No. 05-01670-04, October 15, 2007.

Audit of QTC Medical Services, Inc.'s Settlement Offer for Overcharges under Contract V101(93)P-2009, Report No. 07-02280-104, March 27, 2008.

Audit of Electronic Contract Management System, Release anticipated in 2009.

Audit of Veterans Health Administration's Government Purchase Card Practices, Report No. 07-02796-203, September 11, 2008.

INFORMATION MANAGEMENT

Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2007 and 2006, Report No. 07-01016-21, November 15, 2007.

Fiscal Year 2007 Federal Information Security Management Act Assessment, Report No. 07-00608-162, July 9, 2008.

Audit of the Veterans Health Administration Blood Bank Modernization Project, Report No. 06-03424-70, February 8, 2008.

Statement of the Honorable Robert T. Howard, Assistant Secretary for Information and Technology, Department of Veterans Affairs, Before the House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, April 3, 2008.