STRATEGIC PLAN 2005-2010

OFFICE OF INSPECTOR GENERAL

DEPARTMENT OF VETERANS AFFAIRS

Message from the Inspector General

March 2005

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) is resolved to ensuring VA programs and operations are efficiently and effectively managed, and free of criminal activity, waste, and abuse. We will aggressively investigate, arrest, and prosecute persons perpetrating crimes affecting VA programs. We are committed to fully understanding the key issues in VA, and focusing our resources on these issues to maximize the impact we have on helping the Department accomplish its mission. In accordance with the Government Performance and Results Act of 1993 (GPRA), the OIG has developed a Strategic Plan that describes the structure, goals, and strategies for fulfilling these commitments for Fiscal Years (FY) 2005-2010.

Over the next 6 years, OIG will focus on examining major management challenges and high-risk areas facing VA within five strategic goals of health care delivery, benefits processing, financial management, procurement practices, and information management. In addition to describing the challenges VA faces and the projects OIG will undertake in each area, this plan also establishes performance measures to assess our accomplishments.

These outcome-oriented measures demonstrate how our work is helping VA achieve its mission, improve customer satisfaction, and protect the interests of veterans and their families, as well as the taxpayer. In this 6-year period, this plan directs us to:

- Find over $6 billion in monetary benefits.
- Issue 927 reports recommending improvements and corrective actions.
- Report on 409 inspections of VA's health care and benefits processing operations.
- Achieve the highest possible ratings for OIG's professionalism and competence.
- Accomplish 13,226 arrests, indictments, administrative sanctions, and pretrial diversions, with an 87 percent rate of successful prosecutions.

We expect this plan to remain relevant to the challenges facing VA, but we consider it a living document that is subject to change as necessary. We will consult with the Department and Congress periodically and use the feedback we receive to revise this plan to continually improve our products and services. OIG remains committed to achieving our long-term strategic goals through promoting positive change in VA and, ultimately, improving services to our Nation's veterans.

RICHARD J. GRIFFIN

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CHAPTER I

MISSION, ORGANIZATION, AND RESOURCES

The Department of Veterans Affairs (VA)

In one form or another, American Governments have provided veterans benefits since before the Revolutionary War. VA's historic predecessor agencies demonstrated our Nation's long commitment to veterans. The Department was established on March 15, 1989, when Public Law 100-527 elevated the Veterans Administration to Cabinet-level status.

MISSION

VA's mission is to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to this Nation. This mission comes from Abraham Lincoln's second inaugural address, given March 4, 1865, "To care for him who shall have borne the battle and for his widow and his orphan."

ORGANIZATION

VA has three administrations that serve veterans:

- The Veterans Health Administration (VHA) provides medical care, medical education, medical research, and back-up to the Department of Defense (DoD).
- The Veterans Benefits Administration (VBA) provides compensation and pension, education, vocational rehabilitation, and employment services, insurance coverage, housing programs, and other transition benefits and services.
- The National Cemetery Administration (NCA) provides interment, memorial services, and maintains veteran cemeteries as a permanent tribute from a grateful Nation.

RESOURCES

VA is the second largest Federal employer. For FY 2004, VA employed nearly 220,000 personnel and spent approximately $70 billion to serve 25.2 million veterans. VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Philippines.

Approximately 193,000 of VA's employees work in VHA. Health care funding comprised about 46 percent, or $29 billion, in FY 2004. VHA provided care to an average of 56,000 inpatients daily and almost 54 million episodes of outpatient care in FY 2004. The VA health care organization includes 157 health care systems, 133 nursing home units, 206 veterans centers, 42 VA residential rehabilitation treatment programs (formerly called "domiciliaries"), and 867 outpatient clinics (including hospital clinics).

Veterans benefits funding comprised about 54 percent, or $34 billion, in FY 2004. Approximately 13,000 VBA employees at 57 VA regional offices (VAROs) provided benefits to veterans and their families. Over 2.8 million veterans and their beneficiaries receive compensation benefits valued at $26.3 billion in the largest benefit program. An additional $3.3 billion in pension benefits are provided to approximately 560,000 veterans and survivors.

NCA operates and maintains 120 cemeteries and employed about 1,400 staff in FY 2004. All of VA's burial benefits, including NCA operations, account for approximately $430 million of VA's budget. Interments in VA cemeteries continue to increase each year, with 93,000 burials conducted in FY 2004, and VA provided approximately 350,000 headstones worldwide for placement in VA and other cemeteries. NCA also issued 435,000 Presidential Memorial Certificates on behalf of deceased veterans in FY 2004.

VA Office of Inspector General (OIG)

The OIG is an independent, objective organization within VA that performs oversight functions. The OIG was administratively established in VA in January 1978, and subsequently established as a statutory inspector general (IG) in October 1978 by the Inspector General Act of 1978 (Public Law 95-452). The Act states that the IG is responsible for conducting audits, investigations, and evaluations of VA programs and operations; identifying potential problems or abuses; recommending policies designed to promote economy and efficiency; preventing and detecting criminal activity and abuse; developing and making recommendations for corrective action; and informing the Secretary of Veterans Affairs and the Congress of problems, deficiencies, and the need for corrective action. The IG has authority to inquire into all VA programs and activities, as well as the related activities of persons or parties performing under grants, contracts, or other agreements with VA. For a detailed description of the Inspector General Act and to learn more about the inspector general community, see www.IGNet.gov.

MISSION

The OIG seeks to support VA in achieving its mission as effectively, efficiently, economically, and as free from criminal activity as possible by functioning as catalysts for change.

The OIG mission statement:

> The OIG is dedicated to helping VA ensure that veterans and their families receive the care, support, and recognition they have earned through service to their country. The OIG strives to help VA achieve its vision of becoming the best-managed service delivery organization in Government. The OIG continues to be responsive to the needs of its customers by working with the VA management team to identify and address issues that are important to them and the veterans served.

ORGANIZATION

The VA OIG is organized into three line elements: The Offices of Investigations, Audit, and Healthcare Inspections, and a support element. The four elements are described below. The three line elements join to perform Combined Assessment Program (CAP) reviews that consolidate the knowledge and skills of their offices to perform independent and objective evaluations of selected health care and benefits field operations on a cyclical basis. In addition to the Washington, DC, headquarters, OIG audit, investigation, and health care inspection offices are located in 23 cities throughout the country. The organization chart in Appendix A shows all OIG components. For more information about VA OIG, see www.va.gov/oig.

Office of Investigations

The Office of Investigations (OI) conducts criminal and administrative investigations of wrongdoing in VA programs and operations in an independent and objective manner. OI seeks prosecution, administrative action, and/or monetary recoveries where appropriate as it strives to establish an environment in VA that is safe and free from criminal activity and management abuse.

Office of Audit

The Office of Audit (OA) contributes to the improvement and management of VA programs and activities by providing customers with timely, balanced, credible, and independent financial and performance audits that address the economy, efficiency, and effectiveness of VA operations. OA identifies constructive solutions and opportunities for improvement.

Office of Healthcare Inspections

In 1988, Public Law 100-322 further defined the responsibilities of the OIG to include oversight, monitoring, and evaluation of VHA quality assurance programs and the activities of the VHA Office of the Medical Inspector. These responsibilities reside in the Office of Healthcare Inspections (OHI). OHI promotes the principles of continuous performance improvement; provides effective health care inspections; and enhances and strengthens, through oversight and consultation,

the quality of VA's health care programs for the well-being of veteran patients and their families. In addition to national reviews of specialized VA treatment programs, patient care, and quality assurance issues, OHI also reviews hotline allegations involving medical care issues.

Office of Management and Administration

The Office of Management and Administration contributes to OIG results by providing management, planning, and support services to OIG employees nationwide, across every OIG operational element. Support services include operational support, hotline, budget and finance, administrative services, information technology, and human resources management.

RESOURCES

The FY 2004 funding for OIG operations was enacted as a 2-year appropriation that provides for funds to remain available until September 30, 2005. The FY 2004 funding was $68.4 million, with $61.6 million from appropriations, $3.8 million from FY 2003 carryover, and $3.0 million through a reimbursable agreement with VA for services to perform preaward and postaward contract reviews and other pricing reviews of Federal Supply Schedule contracts.

OIG allocated 432 full-time equivalent (FTE) employees from appropriations for the FY 2004 staffing plan to perform all OIG mandated, reactive, and proactive work. During FY 2004, reactive and mandated work consumed approximately 41 and 6 percent, respectively, with the remaining 53 percent available and used for proactive projects, such as national audits and reviews, CAP reviews, and the Fugitive Felon Program. In addition, 25 FTE are reimbursed for a Department contract review function.

CHAPTER II

STRATEGIC PLANNING

In accordance with GPRA and sound management practice, the OIG operates pursuant to a strategic plan. We identify key issues within VA that present challenges to the Department's ability to achieve its mission of serving veterans in the most effective and efficient manner, direct our resources to produce the greatest impact on meeting those challenges, report our results in terms of outputs as well as outcomes, and reassess our plans based on feedback from customers and stakeholders. This plan reflects the refinement of the 2001-2006 OIG Strategic Plan based on our experience over the past 4 years.

The OIG Strategic Plan was built "from the ground up" by soliciting key issue, project, performance goal, and outcome measure ideas from all OIG employees. We also consulted with experts in other OIGs, and considered the feedback of VA and other customers and stakeholders. This process produced a collaborative plan as well as better understanding by OIG staff of our organization's role and mission. The illustration below identifies the sources of input to our strategic plan.

Input Sources for OIG Strategic Plan

We are presenting a plan which, when implemented, will move us from our goals and strategies to our measurable outcomes. We have refined our performance measures to focus more on intended outcomes rather than primarily on outputs. We have started with the end in mind to focus our resources and strategies on products and outputs that directly influence both interim and long-term mission-related outcomes. Our plan uses a Logic Model to describe the way (or logic) by which we achieve our goals. Table 1 below illustrates examples of the critical linkages in the chain that lead from work to results, from effort to outcomes.

Table 1 – OIG Logic Model

Inputs ⇨	Strategies ⇨	Outputs ⇨	Outcomes	
			Interim	Long-term
OIG Staff Travel Training Technology Skills Planning Leadership Effort Analysis	Audits Investigations Inspections CAPs Satisfaction surveys Hotline cases Follow-up	Reports Referrals Recommendations Arrests Indictments Financial statement opinions Certifications Survey results Best practices identifed	Recommendations implemented Improved policies Improvement of VA operations Best practices adopted Successful criminal prosecutions (convictions, incarceration, fines) Regulatory/legislative changes Improved medical outcomes Reduced error/loss rates Valid and secure data	High-quality health care Increased access to care Timely, accurate benefits Increased efficiency Improved customer satisfaction and trust Monetary savings/ recoveries Reduced criminal activity Improved veteran quality of life

Our Strategic Plan includes five strategic goals in the areas of health care delivery, benefits processing, financial management, procurement practices, and information management that encompass all the key issues that we now anticipate VA will encounter over the next 6 years. For each goal, this plan provides a structure in which we define the specific strategic goal, establish our performance goals linked to the broader strategic goal, set forth the strategies and projects to achieve these goals, and promulgate the measures to assess our progress toward achieving the goals. This plan will act as a template to direct all OIG audits, investigations, and health care inspections. We derive our annual performance plans, which we publish each year in our September Semiannual Report to Congress, from this strategic plan by selecting the urgent, significant issues that require review consistent with efficient use of our resources.

Since neither the OIG nor VA exists in a vacuum, but as part of the larger Executive Branch and Federal Government, we placed particular emphasis on relating our work to other key plans, most significantly the VA Strategic Plan 2003-2008, the VA Major Management Challenges FY 2004, and the President's Management Agenda. We have identified the greatest management challenges and high-risk areas for criminal activity, waste, abuse, and inefficiency facing VA, and have developed strategies and projects targeted at eliminating the major problems associated with these areas. Accordingly, OIG will remain focused on those issues of central concern to the Department and the Administration, and will have greater impact by contributing in a relevant and meaningful way, as Congress intended in the IG Act. As a further incentive to partnering and collaborating in what OIG and the Department can accomplish together, OIG is committed to presenting findings in a positive and timely manner.

Table 2 below demonstrates the direct relationship between this plan and other key plans.

Table 2 – Relevance of OIG Strategic Goals to Key Plans

OIG Strategic Goals	VA Strategic Plan 2003-2008	VA Major Management Challenges FY 2004	President's Management Agenda
Goal #1 HEALTH CARE DELIVERY Improve veterans' access to high-quality health care by identifying opportunities to improve the management and efficiency of VA's health care delivery systems; and by detecting, investigating, and deterring fraud and other criminal activity.	√	√	√
Goal #2 BENEFITS PROCESSING Improve the delivery of benefits and services by identifying opportunities to improve the quality, timeliness, and accuracy of benefits processing; and reduce criminal activity in the delivery of benefits through proactive and targeted audit and investigative efforts.	√	√	√
Goal #3 FINANCIAL MANAGEMENT Assist VA in achieving its financial management mission of providing all VA activities with accurate, reliable, and timely information for sound oversight and decision making; and identify opportunities to improve the quality, management, and efficiency of VA's financial management systems.	√	√	√
Goal #4 PROCUREMENT PRACTICES Ensure that VA's acquisition programs support our Nation's veterans, other Government entities, and the taxpayer by providing its customers with quality products, services, and expertise delivered in a timely fashion, for a reasonable price, and to the right place.	√	√	√
Goal #5 INFORMATION MANAGEMENT Assess information systems within VA to determine that they are adequately managed and protected to ensure information availability, integrity, authentication, and confidentiality; used in a lawful and ethical manner; are cost effective; and meet the needs of the user/ customer. Investigate fraud and other computer related crimes against VA.	√	√	√

The OIG is committed to ensuring our resources are spent in a cost-efficient manner. Our organizational structure reflects the type of work we do and is aligned to achieve our strategic goals. We use performance

measures to determine the impact of our oversight work. For example, during the past 5 years, our cost-benefit ratio has averaged $30 in monetary benefits for every $1 expended. For the semiannual reporting period ending September 30, 2004, OIG reported $37 in monetary benefits for every $1 expended. We use performance and financial data to make decisions such as allocating human resources, opening new offices, shifting resources, funding awards and training, undertaking travel, modernizing information technology, contracting for services, whether we address a hotline case in-house or refer it to VA, and what proactive initiatives to undertake. As the CAP reviews demonstrate, we have deliberately moved in recent years to combine and collaborate on projects to maximize the effectiveness of our multi-disciplinary staff expertise. In every decision to commit OIG resources, we strive to improve VA programs and operations, provide objective and independent information for better decision-making, eliminate criminal activity, highlight accountability, and keep both the Secretary and Congress fully informed of our findings and recommendations.

We recognize that much of what we do does not result in a quantifiable monetary benefit or an immediate result. For example, investigating the untimely death of a veteran, putting a serial killer behind bars, or removing a drug dealer or dangerous fugitive felon employee from one of our hospitals, while directly related to saving lives and making the VA environment safer, does not easily translate into the traditional monetary benefits measure of better use of funds. Similarly, much of the mandated work we do, such as the Consolidated Financial Statement audit or the Federal Information Security Management Act testing of the security of information systems, does not yield direct monetary benefits. As we focus on outcomes in many areas for the first time, we recognize that progress measures require initial baselines. As such, we have established meaningful, quantifiable performance measures wherever possible.

Finally, we recognize that strategic planning is an ongoing process requiring constant measurement and readjustment. The OIG intends to be responsive to the changing environment and our own experience. For example, VA expects to see a large increase in claims resulting from the return of servicemen and women who fought in Operation Enduring Freedom, Operation Iraqi Freedom, and the war on terrorism. With the large troop rotations now underway, VA is likely to experience continuing strong demand for its services from this new generation of veterans. The OIG is dedicated to remaining proactive in helping VA ensure it is fully prepared to meet the new demand as well as to care for its growing geriatric population with its own special needs. We have shown, and will continue to demonstrate, great flexibility in reacting to changing circumstances. We will consult with stakeholders and customers within and outside the Department as necessary to ensure that we are having maximum impact on helping VA achieve its mission of serving those who have kept our Nation free.

CHAPTER III

STRATEGIC GOALS

Strategic Goal #1 – Health Care Delivery

BACKGROUND:

The primary mission of the Veterans Health Administration (VHA) is to serve the health care needs of eligible veterans by providing quality inpatient, outpatient, and long-term health care services. During FY 2005, VHA will spend approximately $30.7 billion and employ a workforce of almost 200,000 people to provide health care and related services to over 5.1 million veterans. VHA also plays a major role in educating the Nation's health care workforce, conducting medical research, and serving as emergency back-up to the DoD and our communities in time of war, natural disaster, or terrorist attack.

Quality of care remains the primary health care focus of both VHA and OIG. Veterans should receive medical care that meets the highest standards. OIG believes that improvements in the measurement and effective use of medical outcomes data will provide opportunities for VHA to improve the health care provided to veterans. We will work with VHA to develop appropriate medical outcome measures consistent with industry and Government standards that demonstrate the level of health care VA provides. Fiscal constraints will demand that VHA improve the efficiency of health care delivery without sacrificing the quality of medical care provided to veterans.

An aging veteran population, the ongoing shift to outpatient and other non-hospital settings for care, the increased reliance on providers who are not full-time VA employees, and the introduction of major pharmaceutical and technological innovations influence the quality of care. These trends will drive the focus of OIG's health care oversight activities over the next 6 years.

During the next decade, VHA will be challenged to provide efficient and effective long-term care and geriatric services to an aging veteran population. Between 1990 and 2004, the veteran population over 65 years of age increased from slightly more than 7 million to 9.1 million veterans, and veterans over 85 years old increased from 164,000 to 864,000. By 2010, veterans will represent 66 percent of the U.S. male population over 85 years of age. In contrast, from 1990 through 2010, the number of younger veterans (those under 45 years of age) will show a significant decline from about 8.3 to 3.3 million. These population changes will cause a dramatic shift in the demand for VA benefits and services.

Historically, VA provided care through a hospital-based delivery system. However, in recent years, VHA restructured health care delivery to emphasize managed care through an extended network of community-based outpatient clinics and ambulatory care units. VHA's transition to a greatly expanded ambulatory care/outpatient care setting, coupled with a realignment of regional management services to 21 Veterans Integrated Service Networks (VISNs), has increased the challenge to provide high-quality care services through a redesigned health care delivery system. The nature of the aging veteran population requires significant attention to specialized resources of geriatric care, extended and nursing home care, end-of-life and hospice care, and home health care. OIG will extensively review each area of care to ensure it is of high quality and the appropriate setting for the veteran.

The realities of competing for health care resources with the private sector, as well as the shift of focus from inpatient to outpatient care, require that VA must obtain more clinical resources than in the past through alternative means to full-time physician employees. VA today provides care through fee-basis services, scarce medical sharing agreements, contract care, and other arrangements in addition to full-time and part-time VA physician employees. OIG will continue to monitor that VA has appropriate staffing models for hiring or purchasing physician services, and that the physicians VA pays are providing the full tour of duty and range of services funded by taxpayer dollars.

Scientific advances and the older veteran population also place greater importance on the role of pharmaceuticals in the treatment of veterans over the next decade. In FY 2004, VHA spent about $2.5 billion on drugs for veterans' health care. VHA negotiates contracts with pharmaceutical companies to obtain the best prices on drugs, and OIG monitors those contracts to ensure VA obtains value from its suppliers. We anticipate that VHA's use of pharmaceuticals will continue to grow substantially. The management of the VHA formulary, the introduction of lifestyle pharmaceuticals, and the use of cost containment strategies that do not adversely impact health care present significant challenges for VHA. OIG will remain active in reviewing pharmaceutical issues to ensure legal requirements are met, good business practices occur, and pharmaceutical therapy practice is of high quality.

Information Age technology has revolutionized health care. VHA faces challenges in managing clinical information related to documentation of clinical management and utilization of medical outcomes data. Other information technology challenges are discussed separately under the information management strategic goal in this plan.

As the Nation's largest health care system, VA is also involved in cutting edge scientific and medical research in all disciplines and specialties of health care. OIG will continue to exercise oversight of research activities to ensure public monies are well spent and that patient rights are protected.

In FY 2004, VHA employed 72,000 clinicians, including 9,500 physicians and 57,000 nurses, and is a major force in the education of the Nation's health care workforce. Several recent OIG inspections and reviews have revealed inadequate documentation by VHA to ensure the appropriate level of supervision of clinicians in training who provide care to veterans. Proper documentation of clinical supervision is a necessary element of VHA health care and must be improved in the coming years. We will continue to review supervision and documentation issues in our health care projects.

VA has several management improvement initiatives underway that will affect VHA's delivery of health care services. The finance, acquisition, and capital asset management functions will be centralized at VA headquarters, and these functions will be realigned into a single business office in each of the 21 VISNs. This realignment is intended to significantly strengthen compliance and consistency with finance, acquisition, and capital asset policies and procedures. In response to new Federal requirements, VA and VHA have undertaken several major initiatives to address capital planning. In addition, deciding where new health care facilities such as outpatient clinics are to be located, how best to deal with under-utilized hospitals, and allocation of staff and resources of major equipment and technology purchases are a few of the issues at the forefront of capital asset planning. We will monitor the effects of management initiatives and resource reallocations on efficient operations of the Department as well as on quality of care.

In September 2004, women veterans numbered 1.69 million, or almost 7 percent of the veteran population. The number of women enrolled in VA health care increased 67 percent from FY 2000 to FY 2004 to a total of 378,000. We will review women's health services to ensure VA is adapting to this rapidly-expanding patient base.

Providing safe, accessible, high-quality medical care, and reasonable patient waiting times are just some of the fundamental delivery of service issues that present challenges on a continuing basis. Effectively dealing with these challenges requires vigilant management and evaluative oversight. VHA must maintain a fully functional Quality Management (QM) program that ensures high-quality patient care and safety, and safeguards against the occurrence of adverse events. OIG will conduct ongoing oversight of the VHA QM program and VHA's Office of Medical Inspector, the Office of Quality and Performance, and the National Center for Patient Safety, pursuant to the statutory mandate of Public Law 100-322, to maintain the focus on high-quality care.

STRATEGIC GOAL #1 — Health Care Delivery

Improve veterans' access to high-quality health care by identifying opportunities to improve the management and efficiency of VA's health care delivery systems; and by detecting, investigating, and deterring fraud and other criminal activity.

PERFORMANCE GOALS:

1. **Improve the quality of health care provided to veterans with VA funds.**
2. **Ensure that veterans who require life-sustaining care receive their care in the most appropriate setting.**
3. **Ensure that VHA health care funds are appropriately and efficiently utilized.**
4. **Minimize the impact of criminal activity, waste, and abuse upon the delivery of quality health care to veterans.**

STRATEGY/PROJECTS:

Joint Projects:

- **Management of medical services.** We will continue CAP reviews of VHA facilities' provision of medical services to veterans and eligible beneficiaries with emphasis on medical outcomes and access to care. In addition to individual CAP reports, we will issue consolidated CAP summaries addressing findings and recommended actions to improve health care operations and identify emerging issues.
- **Physician time and attendance.** OA and OI will continue oversight of physician time and attendance abuses to ensure that the taxpayers are receiving the medical services for which VA is paying.
- **Physician and nurse staffing levels.** OA and OHI will continue oversight of physician and nurse staffing in all areas to ensure that VA establishes and implements comprehensive staffing standards for all VA physicians and nurses.

- **Medical Care Collection Fund (MCCF) follow-up.** OA will follow-up on the implementation of recommendations contained in prior reports and identify additional opportunities needed to further enhance MCCF collections and controls over the related revenues. OHI will review documentation in VHA medical facilities.
- **Coding and billing practices.** OA and OHI will evaluate the effectiveness of VHA's efforts to meet billing compliance regulations and to review the accuracy of coding medical services provided to veterans.
- **Pharmacy fee-basis program.** OA and OHI will review this program to determine adequacy of VHA controls over the distribution activities.
- **Access to long-term care.** OA will audit VA's compliance with access to the long-term care provisions of the Veterans Millennium Health Care and Benefits Act (Public Law 106-117) and review to ensure access to VHA provided and VHA funded long-term nursing home care is managed in an equitable manner and in accordance with statutory requirements. OHI will review compliance with clinical requirements.
- **Utilization review.** OA and OHI will monitor whether VA physical plant is efficiently used and whether cost savings and quality care will result from consolidation of services among little-used facilities.
- **Emergency preparedness.** OA and OHI will determine whether: VHA facilities conducted building inspections and made enhancements to remedy discovered weaknesses as directed by Public Law 107-188 and Public Law 107-287; facility emergency plans address chemical, biological, and radiology emergencies as well as fire, weather, and other types of emergencies, and includes training of appropriate personnel for these emergencies; the level of the VHA facility and community involvement in disaster planning, decontamination, and hospital readiness complies with Public Law 107-188 and JCAHO standards; and employees are trained appropriately in emergency preparedness and disaster response.
- **Major research activities.** OA and OHI will review research protocols funded by pharmaceutical companies to ensure clinical priorities are not supplanted, that patient rights are protected, and VA resources are efficiently and appropriately employed.
- **Medical education.** OA and OHI will review VHA's education activities to ensure that clinical staff is appropriately employed, that VA gets the services it pays for, and patient rights are protected.
- **Associated health professionals disbursement agreements.** OA will review these agreements to detect contracts that are not in VA's best interest and potential overpayments and fraud, such as payments for services not rendered. OHI and OI will participate as appropriate in clinical consultations and fraud investigations.

- **Hotline complaints and best practices.** OA, OHI and OI will evaluate particular complaints or events, through hotline reviews, administrative investigations, and criminal investigations, and disseminate best practices and lessons learned as they apply to systemic improvements in health care delivery through report recommendations.

Office of Audit:

- **Community-Based Outpatient Clinic planning process and management controls.** OA will assess their effectiveness in an evaluation.
- **Capacity for specialized medical treatment.** OA will certify VA's report to Congress on maintenance of capacity for specialized treatment and the rehabilitative needs of veterans by examining the reliability and validity of the information.
- **Location of new offices and facilities in rural areas.** OA will assess VA policies and procedures that are in place to give first priority to the location of new offices and other facilities in rural areas, as directed by the Rural Development Act of 1972.
- **Waiting list scheduling and data validity.** OA will verify the accuracy of the reported Medical Care Waiting Lists and evaluate compliance with waiting list policies and procedures.
- **Use of fee-basis appointments.** OA will assess how VHA's medical facilities use fee-basis appointments to provide services on station and examine whether fee-basis appointments are cost effective and appropriate for providing health care services.
- **Pharmacy and drug accountability.** OA will assess physical and cost controls for selected controlled substances and high-risk non-controlled drugs during CAP reviews at VHA medical facilities.
- **Telemedicine initiatives.** OA will conduct an audit to determine whether VHA decisions to establish telemedicine programs are based on a comprehensive assessment of associated costs and benefits, management information systems are reliably reporting program costs, and management oversight activities have been effective.
- **Nanotechnology testing and development.** OA will evaluate whether VA has an effective research program to study and invest in nanotechnology applications.
- **Contracted community nursing home services.** OA will examine VHA's efforts to identify and recover erroneous payments for nursing home services, and review uses of scarce medical funds to ensure the provision of effective care of VA patients. We will also examine VHA's efforts to ensure the safety and health of veteran patients in nursing homes.
- **Contract physician services.** OA will conduct an audit to determine whether needs assessments were conducted and appropriate,

whether contract monitoring was adequate, whether billings were correct, if conflicts of interest exist in the contracting process and contract monitoring, and if appropriate staff provided services and basis for payment was proper.

- **Off-station fee-basis care.** OA will review this issue to determine the basis for off-station fee costs (for example, Medicare or negotiated rates), examine the use of contracts instead of the fee-basis program, and evaluate the reduction or elimination of fee-basis costs for unnecessary medical procedures identified through the utilization review process.
- **On-station fee-basis care.** OA will review this issue to determine the basis for on-station fee-basis fee costs (for example, Medicare or negotiated rates), ensure the use of fee-basis to pay for services that medical schools should provide (for example, physicians substituting for VA physicians working at the schools); examine the use of contracts instead of the fee-basis program, and evaluate the reduction or elimination of fee-basis costs for unnecessary medical procedures identified through the utilization review process.
- **VA research and education corporations.** OA will assess whether VHA's guidance and management controls at the national, network, and local levels ensures research and education organizations are complying with legal and regulatory guidelines. We will also focus on examining the sources and uses of VA and non-VA funds including compliance with restrictions on specific donations.
- **Physician pay.** OA will conduct an audit to determine appropriateness of the process to set and administer this pay to ensure that VA complies with statutory requirements.
- **Veterans Equitable Resource Allocation (VERA).** OA will identify opportunities to improve funding and resource allocations methodologies among VA networks and facilities and eliminate factors that inhibit effective resource allocation.
- **Physician Special Pay.** OA will review this issue to evaluate the appropriateness of the process of granting physician special pay and the appropriateness of the process to waive physician special pay debts.

Office of Healthcare Inspections:

- **Pharmacy internal controls and patient safety issues.** OHI will assess the utilization of high-cost/high-risk medications.
- **Operating rooms.** OHI will determine whether medical facility managers have established and implemented effective policies, procedures, and guidelines to ensure patient safety in the operating room.
- **Homeless veterans.** OHI will determine whether: homeless veterans receive appropriate assessment and treatment services;

facilities evaluate effectiveness of their housing programs; individual programs achieve program goals; and cost-outcome analysis supports VHA's decision to eliminate residential care in favor of Grant and Per Diem and Per Diem Only programs.

- **Pressure ulcers.** OHI will determine whether VHA clinicians are providing comprehensive pressure ulcer prevention and management.
- **Medical outcomes.** OHI will develop a system of selected medical outcome measures to fairly represent quality of health care for in-patient, ambulatory, medical, surgical, and behavioral health settings, using available information and recognized industry/Government standards where appropriate. When developed, we will incorporate the outcome measures into all OIG health care reviews to establish baselines and progress concerning quality of health care. For example, CAP reviews of a particular VA medical center (VAMC) or VISN would include electronic data extraction prior to review to identify those weak areas and strengths to focus on in the CAP review and highlight in the report. National reviews would be undertaken for each of the measures to establish baselines and demonstrate progress, both facility and VA-wide.
- **Resident supervision.** OHI will review medical record documentation and other indicators used to support resident supervision.
- **Quality Management.** OHI will review VHA programs of internal quality management of medical and research activities.
- **Clinical consultation timeliness.** OHI will assess the timeliness of specific specialty services' consultations for diagnostic services.
- **Women's health services.** OHI will determine whether VA Community Based Outpatient Clinics are providing mammography services for women veterans that is in compliance with the American College of Radiology standards; and if women veterans are satisfied with their care.
- **VA/DoD sharing agreements.** OHI will determine to what extent VA and DoD are utilizing sharing agreements, what resources are being shared, and identify possible barriers to further collaboration.
- **Hospice services.** OHI will evaluate the quality of care and cost effectiveness of hospice care.
- **Behavioral health programs.** OHI will assess access and quality of mental health care services in VHA Community Based Outpatient Clinics.

- **Office of Medical Inspector.** OHI will review the VHA Office of Medical Inspector as part of our mandated responsibility to provide oversight of that office's operations.

Office of Investigations:

- **Fraud awareness.** OI will conduct fraud awareness briefings during CAP reviews of VHA and VBA facilities to increase employee consciousness regarding the indicators of fraud and criminal activity and the procedures for referring criminal issues to OIG.
- **Drug diversion and pharmacy theft.** OI will initiate drug diversion criminal investigations based on a comparison of verified death match data with VHA pharmacy records, and based on allegations of theft reported to the OIG.
- **Medical benefits fraud.** OI will initiate criminal investigations involving fraud in the health care system including claims for medical benefits, unauthorized care, workers' compensation, and beneficiary travel.
- **Employee misconduct and criminal activity.** OI will initiate criminal and administrative investigations of wrongdoing within the VA health care system, to include instances of patient abuse, conflicts of interest, resources misuse, travel abuse, and misuse of official time (e.g., time and attendance, official timekeeping).
- **VHA facility safety.** OI will initiate joint investigations with the VA Police relating to crimes committed by VA employees, patients, and visitors in order to ensure safety of VA medical facilities.

PERFORMANCE MEASURES:

Outputs

- Issue 343 reports that identify opportunities for improvement and provide recommendations for corrective action, including national audit, health care inspections, and joint reviews on health care delivery issues.
- Include relevant health care delivery review areas in 310 CAP reviews (including 6 CAP summary reports) and complete a cycle of CAP 2.0* protocol reviews VHA-systemwide.
- Conduct follow-up to ensure implementation of OIG recommendations.
- Conduct customer satisfaction surveys on every OIG project.

* The OIG CAP reviews are multidisciplinary reviews of specific health care facilities and systems. Having completed one nationwide cycle, OIG is revising its CAP protocol to make the next round of reviews even more effective and relevant. OIG refers to the revised procedures and second cycle internally as "CAP 2.0."

- Contribute to 4,765 arrests, indictments, and informations in criminal investigations involving health care programs and operations, (e.g., pharmaceutical theft and diversion, patient abuse, false claims by vendors).
- Identify and disseminate VHA's best practices in health care programs and operations to improve VA health care delivery through report recommendations.
- Conduct 500 fraud awareness briefings.

Interim Outcomes

- Prompt implementation of OIG recommendations resulting in the adoption of policy changes, best practices, and improved efficiencies.

  Measures:

  ✓ VHA implements 90 percent of new recommendations within 1 year.

  ✓ VHA implements 100 percent of past and new recommendations within 3 years.

- Professional, competent, and credible reputation.

  Measure:

  ✓ OIG is rated 5.0 on a scale of 1 - 5 (5 is high) in customer satisfaction survey results from all our internal and external customers (e.g., VA management and staff, U.S. Attorneys, etc.).

- Improved quality in VA's health care programs and operations in terms of medical outcomes to assess VHA's efforts to ensure that the highest quality of appropriate medical care is provided to veterans.

  Measure:

  ✓ OHI's trended measures of patient outcomes for VHA facilities compared to VA and national norms.

- Improved documentation to ensure that medical records accurately reflect the care provided to veterans and properly document the level of supervision of VHA providers to ensure that all care provided to veterans is under the guidance of properly trained and credentialed providers.

Measures:

- ✓ VHA medical records have 95 percent appropriate provider documentation.
- ✓ VHA medical records have 95 percent appropriate supervision documentation.

- For those conditions affecting a veteran that cannot be improved, assess each VHA program to determine the effectiveness and impact in conserving a veteran's level of function or medical condition.

  Measures:

  - ✓ Development of sufficient policy and directive.
  - ✓ Success in meeting program objectives.
  - ✓ Program effectiveness and efficiency.

- Effective and efficient utilization of human resources.

  Measure:

  - ✓ VHA determines 100 percent of physician and nurse positions through a staffing standard.

- Proper collection and use of MCCF funds and other available health care resources within VHA.

  Measure:

  - ✓ VHA collects 90 percent of possible third party collections.

- Minimize the impact of criminal activity, fraud, waste, and abuse on the delivery of quality health care to veterans.

  Measures:

  - ✓ At least 87 percent of criminal prosecutions and administrative actions against individuals and companies are successful.
  - ✓ Monetary impact of OIG criminal and strategic actions, including fines, penalties, restitutions, civil penalties, recoveries, efficiencies, funds put to better use, and cost avoidance is $1.8 billion.

Long-Term Outcomes

- Consistently high-quality health care to all eligible veterans.
- Convenient, prompt access to care for all eligible veterans.
- Veterans who require life-sustaining care receive their care in the most appropriate setting.
- Efficiency, economy, and integrity in VA's health care programs and operations that serve as a model for health care delivery in the private and public sector, worldwide.
- Three billion dollars put to better use; dollars reclaimed; and recoveries, fines, and penalties in specific health care program areas.

LINKAGE TO VA AND GOVERNMENTWIDE GOALS AND OBJECTIVES:

- **VA Strategic Plan:** The OIG strategic goal #1 will assist VA in restoring the capability of veterans with disabilities to the greatest extent possible and improve the quality of their lives and that of their families (VA Goal 1); ensuring a smooth transition for veterans from active military service to civilian life (VA Goal 2); honoring and serving veterans in life for their sacrifices on behalf of the Nation (VA Goal 3); contributing to the public health and emergency management of the Nation (VA Goal 4); and delivering world-class service consistent with sound business principles that result in effective management of people, communications, technology, and governance (VA Enabling Goal).
- **President's Management Agenda:** The OIG strategic goal #1 furthers the President's Governmentwide initiatives for strategic management of human capital, expanded electronic Government, and coordinating VA and DoD programs to provide seamless service and avoid wasteful duplication. Our goals emphasize appropriate staffing standards, oversight of VA's reliance on technology in health care programs and operations, and effective use of VA's health care resources.
- **Major Management Challenges:** The OIG strategic goal #1 addresses all VA Major Management Challenges in this category: physician time and attendance, staffing guidelines, quality management, long-term health care, security, and safety.

Strategic Goal #2 – Benefits Processing

BACKGROUND:

In addition to its vast program of health care services, VA provides veterans and their dependents a broad array of benefit programs primarily designed to aid in the transition from military service, compensate for injury or death, and honor veterans' service. Benefit programs covering Compensation and Pension, Education, Loan Guaranty, Vocational Rehabilitation and Employment, and Life Insurance deliver about $35 billion in annual monetary benefits. VA administers these benefit programs through the Veterans Benefits Administration's (VBA) network of regional offices, benefit offices, and at Department of Defense (DoD) sites where service personnel get discharged. VBA also works closely with Veterans Services Organizations in developing claims and conducting programs of outreach to inform veterans on the range of benefits.

The Compensation and Pension (C&P) program, with almost 3 million recipients, provides monthly payments to eligible veterans and dependents. The estimated expenditures in FY 2005 of over $33 billion make it the most significant program in financial terms. VBA faces great difficulty in processing these benefits claims in a timely and accurate manner. Factors such as the complexity of benefits laws, court decisions interpreting those laws, technology issues, workload, and staffing have all contributed to a challenging environment for many years. Now, at a time when our Nation's service members are waging a war against terrorism, and fighting in Iraq and Afghanistan, the ability of VA to provide timely and quality decisions becomes even more critical.

In FY 2004, VBA's goal for C&P inventory of claims pending rating decisions was 250,000 claims. As of September 2004, the actual inventory was over 321,000. For timeliness, VBA sought to process this same workload within 100 days of claim filing. The September 2004 actual performance was 163 days. The 12-month average on the actual quality of work on these claims in September 2004 is 87 percent, compared to VBA's FY 2004 goal of 90 percent. Remands and appeals for claims already initially decided also continue at levels exceeding VBA's goals. As of September 2004, the pending remand inventory at the regional offices was 6,600 cases versus a goal of 3,000. Remands consolidated at the Appeals Management Center exceed 23,000 cases at the end of September 2004. The inventory of appeals is running about 13 percent over goal, with over 107,000 pending at the regional offices as of September 2004.

Similar concerns regarding timeliness and quality also exist in most other benefit programs, including some of the benefit programs in which VBA has contracted out significant aspects of the work. In programs such as Vocational Rehabilitation and Employment, designed to assist seriously disabled, service-connected veterans regain independence and employment success, OIG Combined Assessment Program reviews

have found instances of delays in processing claims and opportunities to improve the supervision and guidance of program participants. Prior OIG work in the Loan Guaranty program indicates a need to continue projects in areas such as loan underwriting and vendee sales. A notable exception, the VBA Life Insurance program, appears to operate at levels that exceed industry standards for customer satisfaction and internal performance metrics. As such, OIG work in this benefit area, with the exception of information technology security and financial statement auditing, will remain primarily reactive. Analogously, OIG's oversight of the NCA memorial affairs and burial programs is primarily reactive in response to complaints of employee or vendor wrongdoing. Proactive projects will focus on the effectiveness and efficiency of benefits programs.

The President's Management Agenda placed emphasis across the Federal Government to reduce the amount of erroneous payments made by agencies, particularly in monetary entitlement programs such as VA C&P. OIG has devoted, on both reactive and proactive projects, considerable audit and investigative resources to support VA in this initiative. For example, in areas such as the fugitive felon project, death match projects, incarcerated veteran reviews, and international benefit payments, OIG personnel worked closely with VA program managers to identify erroneous payments, remediate the causes, and recover funds.

In conjunction with a rise in the number of compensation claims, and a continuing trend for veterans to claim more service-connected conditions than their predecessors, VBA is in the middle of losing some of its most experienced claims processing employees. Historically, hiring in the benefits area of VA runs in cycles linked to major military events. After World War II, VA hired thousands of employees to assist returning veterans. In the early 1970's, as this "Class of '46" retired, VA reached out again to hire replacements – largely Vietnam veterans. Many of these employees, who hold key positions in the claims processing area, are quickly becoming eligible to retire and are doing just that. OIG oversight work will measure the impact of this loss of talent, making recommendations on ways to counter and overcome the negative effect.

OIG will continue to initiate projects to assess steps VBA takes to improve operations, reduce erroneous payments, or overcome the loss of institutional knowledge to retirement. As VBA continues to consolidate operations, such as the establishment of Pension Management Centers, or further efforts to outsource work involved in VA's benefit programs, OIG will consult with VA leadership, Congress, and the Office of Management and Budget in determining projects that improve service to veterans; eliminate fraud, waste, abuse, and criminal activity; and provide a better use of funds.

As with any monetary benefits programs, opportunities arise for unscrupulous individuals to steal benefits payments from unsuspecting or vulnerable recipients, or to defraud VA through fictitious or exaggerated claims. The advanced age or disabilities of many veterans receiving VA benefits makes these individuals particularly vulnerable, especially from

those responsible for their care and affairs, such as fiduciaries and family members. While criminal activity is a relatively small proportion of VA's overall benefits activities, the magnitude and scope of VA programs make the benefits area a significant area for OIG oversight. Detecting and prosecuting criminal fraud in benefits programs is a major activity of the OIG Office of Investigations.

The OIG's oversight will assist VA in ensuring that the pressures to deliver benefits more timely and accurately do not defeat an appropriate level of controls needed to deter and detect fraud, waste, abuse, and criminal activity.

STRATEGIC GOAL #2 — Benefits Processing

Improve the delivery of benefits and services by identifying opportunities to improve the quality, timeliness, and accuracy of benefits processing; and reduce criminal activity in the delivery of benefits through proactive and targeted audit and investigative efforts.

PERFORMANCE GOALS:

1. **Ensure timely and accurate delivery of benefits to eligible recipients.**
2. **Reduce erroneous and fraudulent payments and ensure compliance with all applicable laws and regulations.**
3. **Recoup tax dollars lost to waste, criminal activity, and abuse.**
4. **Protect the system from identity theft, misuse, criminal activity, and inefficiency.**
5. **Ensure data validity of the benefits delivery system.**
6. **Improve VA's customer service, including effective transition and outreach services.**

STRATEGY/PROJECTS:

Joint Projects:

- **Management of benefits services.** We will continue CAP reviews of VBA regional offices' provision of benefits services to veterans and eligible beneficiaries with emphasis on benefits outcomes. In addition to individual CAP reviews, we will issue consolidated CAP summaries addressing findings and recommended actions to improve benefits operations and identify emerging issues.
- **Variance in disability compensation rates.** OA and OHI will review the variance in average annual disability compensation rates by states to determine whether and to what extent VBA can reduce or eliminate variance unrelated to the merits of individual claims.

Office of Audit:

- **Pension Management Centers.** OA will evaluate the efficiency and effectiveness of VBA's consolidation of pension management into three centers with particular emphasis on accuracy of benefits processing.
- **VETSNET initiative.** OA will audit VBA's actions to determine if this information management system development initiative meets user needs and design specifications. We will also assess the reasonableness of project costs and schedule implementation.
- **Benefit payments involving incompetent veterans.** OA will evaluate the impact of reestablishing estate limitations for incompetent veterans, and assess the adequacy of management controls to protect such veterans' estates. The audit is also addressing the adequacy of management controls and oversight of the program.
- **Reasonableness of selected VBA compensation ratings.** OA will evaluate the reasonableness of VBA rating decisions made on the claims of current and former VBA employees. We will look to identify instances where ratings and awards of current or former employees were increased due to consideration of false medical evidence, favoritism toward fellow VBA employees or retired employees, or collusion between employees.
- **Post-Traumatic Stress Disorder (PTSD).** OA will evaluate accuracy and consistency of VBA's decisions to grant service connected benefits for PTSD. We will review veterans' claims to determine if claims provided adequate evidence supporting the PTSD diagnosis.

- **Committee on Waivers and Compromises waiver decisions on benefit debts.** OA will validate the operation of this program, which currently grants waivers for over 60 percent of the requests processed. In particular, we will determine whether the quality review process provides indications that the program operates consistent with the legal requirements and that claimants receive consistent decisions across regional offices.
- **Systematic Technical Accuracy Review (STAR) for C&P Claims Processing.** OA will audit the STAR program, VBA's quality assurance program, to determine its effectiveness in measuring the quality and timeliness of VBA claims processing. We will determine if VBA uses the STAR data effectively to accurately measure quality, manage pending work, improve performance in its Veterans Service and Pension Management Centers, and in assessing training needs of its workforce.
- **Loan Guaranty program — loan underwriting.** OA will audit VA's Loan Guaranty Program underwriting processes to determine if VA internal controls and program oversight of private mortgage lenders are effective at preventing criminal activity, waste, and abuse.
- **Loan Guaranty program — vendee loan sales.** OA will audit VA's vendee loan program to ensure program effectiveness that VA oversight of its contractors provides sufficient safeguards of VA's assets.
- **C&P examinations.** OA will conduct a national audit to assess the physical examination process used in VA to support determinations on the eligibility for C&P monetary benefits. The audit will focus on the timeliness and quality of the process. In particular, we will focus on the sufficiency of the examination for rating purposes.
- **Vocational Rehabilitation & Employment (VR&E) Program.** OA will audit the VR&E program to determine whether it successfully assists seriously disabled, service-connected veterans in overcoming employment barriers related to their injuries and in making them more independent in daily living. The assessment will evaluate traditional program metrics on timeliness, quality, and post-program status. In addition, it will comment on overall program effectiveness and the use of resources, credit cards, contract services, and the propriety of expenditures.
- **Benefit check processing.** OA will evaluate the current VBA policy on terminating electronic fund transfers of monetary benefits. The policy leads to the automatic generation of checks to the last known address of a veteran having a running award upon notice from financial institutions that the payee account was closed. In some cases, this practice leads to erroneous payments sent to deceased or relocated veterans that are cashed by unscrupulous individuals.

- **Succession planning.** OA will review the impact of this loss of talent, making recommendations on ways to counter and overcome the negative effect on VBA benefits services and operations.
- **Iraq/Afghanistan/War on Terrorism benefits.** OA will evaluate VA's performance and plans to provide appropriate services and benefits to returning veterans of these recent and ongoing military conflicts. We will assess the challenges that exist in providing benefits that will facilitate a swift transitioning of returning veterans back to civilian life through VA and DoD efforts.

Office of Investigations:

- **Fugitive Felon Program.** OI will carry out the statutory requirement that prohibits the provision of specific benefits to fugitive felons. We will continue to obtain additional files of fugitives from states that do not comprehensively report fugitive felons to the National Crime Information Center through new and extended memoranda of understanding. We will conduct computer matches between this law enforcement fugitive felon data and VA records. As a result, we will continue the reduction of erroneous payments and improve safety in VA by arresting violent fugitives. We will continue to review the benefit suspension activity in VA to ensure compliance with the intent of the law.
- **International Benefit Review.** OI will evaluate the propriety of VA benefit payments going to locations outside the United States. VBA provides millions in monetary benefits each month to beneficiaries living outside the continental United States. In many instances, these veterans or dependents have not had contact with VA for years. Prior reviews involving the Philippines and Puerto Rico have uncovered erroneous payments in the millions. Future reviews will include Europe, Canada, and Mexico.
- **Death Match.** OI will systematically assess entitlement to VA benefits through a proactive data matching project that compares a variety of VA database files against Social Security Administration (SSA) death data to identify, investigate, and prosecute those defrauding VA by continuing to receive benefits after the veterans' or beneficiaries' deaths.
- **Loan Guaranty fraud.** OI will investigate allegations of loan guaranty fraud and refer substantiated findings to appropriate officials to hold wrongdoers accountable and recover losses to the Government.
- **Fiduciary fraud.** OI will investigate allegations of fiduciary fraud and refer substantiated findings to appropriate officials to hold wrongdoers accountable and recover losses to the Government.
- **Employee misconduct and criminal activity.** OI will initiate criminal and administrative investigations of wrongdoing involving the VA benefits system, to include instances of theft, fictitious claims,

conflicts of interest, resource misuse, travel abuse, and misuse of official time (e.g., time and attendance, official timekeeping).

- **Fraud awareness.** OI will conduct fraud awareness briefings as part of CAP reviews of VBA and VHA facilities to increase employee consciousness regarding the indicators of fraud and criminal activity in benefits programs and the procedures for referring criminal issues to OIG.
- **Pension fraud — Income Verification Match (IVM) and Eligibility Verification Report (EVR).** In collaboration with VBA's C&P Service, OI will pursue fraud through a proactive initiative that will compare and contrast income information provided in different reports, claims, and databases. Appropriate OIG staff will assess the results and coordinate with VBA, with a goal of holding wrongdoers accountable, reducing erroneous payments, and recovering funds.
- **Defense Manpower Data Center match.** In an effort to counter an increasing incidence of identity theft to gain monetary or medical benefits from VA, OI will conduct computer matches of VA and DoD records to identify fictitious veterans who may be receiving VA benefits or actual veterans ineligible for benefits. The matching initiatives will identify records for further investigation by selecting data elements that conflict when comparing or contrasting the electronic files.

PERFORMANCE MEASURES:

Outputs

- Conduct 99 VBA CAP reviews and issue 99 CAP reports including 6 summary reports.
- Issue 99 audit reports on benefits programs and issues that identify opportunities for improvement and provide recommendations for corrective action.
- Conduct three international benefit reviews.
- Conduct follow-up to ensure implementation of OIG recommendations.
- Conduct customer satisfaction surveys on every OIG project.
- Contribute to 7,669 arrests, indictments, and informations in criminal investigations involving benefits programs and operations (e.g., fugitive felons, benefits fraud, fiduciary fraud, employee embezzlement, false claims by vendors).
- Identify and disseminate best practices in benefits program and operations that will improve VA benefits delivery through report recommendations.
- Conduct 150 fraud awareness briefings.

Interim Outcomes

- Prompt implementation of OIG recommendations resulting in the adoption of policy changes, best practices, and improved efficiencies.

  Measures:

  - ✓ VBA implements 90 percent of new recommendations within 1 year.
  - ✓ VBA implements 100 percent of past and new recommendation within 3 years.

- Professional, competent, and credible reputation:

  Measure:

  - ✓ OIG is rated 5.0 on a scale of 1 - 5 (5 is high) in customer satisfaction survey results from all our internal and external customers (e.g., VA management and staff, U.S. Attorneys, etc.).

- Collection of erroneous payments and overpayments due VA.

  Measure:

  - ✓ VBA collects 90 percent of identified payments.

- Improved quality in VA's benefits programs and operations.

  Measure:

  - ✓ VBA improves timeliness and accuracy ratings above baselines to be established.

- Minimize the impact of criminal activity, fraud, waste, and abuse on the delivery of quality benefits services to veterans.

  Measures:

  - ✓ At least 87 percent of criminal prosecutions and administrative actions against individuals and companies are successful.
  - ✓ Monetary impact of OIG criminal and strategic actions, including fines, penalties, restitutions, civil penalties, recoveries, efficiencies, funds put to better use, and cost avoidance is $871 million.

- Improve validity of data of the benefits delivery system.
- Improve compliance with all applicable laws and regulations.

Long-Term Outcomes

- Timely and accurate delivery of benefits to eligible recipients: the right benefits to the right person at the right time.
- Convenient, prompt access to benefits services for all eligible veterans.
- Efficiency, economy, and integrity in VA benefits programs and operations that serve as a model for benefits delivery in the private and public sector, worldwide.
- Three billion dollars put to better use; dollars reclaimed; and recoveries, fines, and penalties in specific benefits program areas.
- Elimination of erroneous and fraudulent payments.
- A benefits delivery system protected from identity theft, misuse, and criminal activity.
- Satisfied VA customers.

LINKAGE TO VA AND GOVERNMENTWIDE GOALS AND OBJECTIVES:

- **VA Strategic Plan:** The OIG strategic goal #2 will assist VA in restoring the capability of veterans with disabilities to the greatest extent possible and improve the quality of their lives and that of their families (VA Goal 1); ensuring a smooth transition for veterans from active military service to civilian life (VA Goal 2); honoring and serving veterans in life for their sacrifices on behalf of the Nation (VA Goal 3); and delivering world-class service consistent with sound business principles that result in effective management of people, communications, technology, and governance (VA Enabling Goal).
- **President's Management Agenda:** The OIG strategic goal #2 furthers the President's fourth Governmentwide Initiative, Expanded Electronic Government. Our strategies of collaboration and interoperability with SSA, DoD, and State and local law enforcement help to ensure VA shares data and works together to consolidate efforts and break down bureaucratic divisions. Additionally, our strategies, performance goals, and performance measures directly contribute to ensuring reliability and reducing erroneous payments by VA. Finally, our strategic goal #2 supports the President's Program Initiative, Coordination of Veterans Affairs and Defense Programs and Systems. We are combining the efforts of our Offices of Audit

and Healthcare Inspections to assist VA and DoD in coordinating programs to provide seamless service to veterans and avoid wasteful duplication.

- **Major Management Challenges:** The OIG strategic goal #2 addresses VA Major Management Challenges by helping VA to ensure quality of life after service, compensation and pension timeliness, identifying erroneous and improper payments, and deterring and reducing fraud and abuse. OIG strategies and projects help VA to ensure the adequacy of the C&P Program's internal controls, ensure data validity, and recoup tax dollars.

Strategic Goal #3 – Financial Management

BACKGROUND:

The financial management organization in VA exists to provide information for sound management decision making to aid in the delivery of high-quality services to veterans and their families. The principal processes are the financial reporting control environment, payments, budget controls, and compliance and operations controls.

VA managers use more than 60 financial management systems and applications for managing VA resources. Over 3,000 employees serve in financial management positions throughout VA. VA employees have stewardship responsibilities for an annual budget of approximately $67.7 billion in 2005 and accountability for safeguarding assets totaling about $49 billion.

The Federal Financial Management Improvement Act of 1996 (FFMIA) requires agencies to have financial management systems that generate timely, accurate, and useful information with which to make informed decisions and to ensure accountability on an ongoing basis. VA faces challenges in building and maintaining an integrated financial management system that complies with FFMIA. Recent attempts to provide an integrated financial and logistical systems has experienced significant technical and contracting problems that have seriously limited VA's ability to comply with FFMIA.

The Government Management Reform Act of 1994 and FFMIA further mandate that Federal agencies improve accountability by improving financial reporting systems, including the requirement for improving information system security, while also complying with Federal accounting standards. The annual audit of VA's consolidated financial statements, conducted by an independent public accountant overseen by OIG, includes a review of VA's compliance with these laws.

Although VA has achieved unqualified audit opinions on its consolidated financial statements since 1999, and has shown improvement in several areas of financial management, material weaknesses continue and corrective actions to address non-compliance with financial system requirements remain several years from completion. Recent OIG work identified major challenges in VA's debt management and Medical Care Collection Fund (MCCF). We have recommended that VA more aggressively collect debts, improve debt avoidance practices, streamline and enhance credit management and debt establishment procedures, and improve the quality and uniformity of waiver decisions. While VA has addressed many of the reported concerns, we continue to identify areas where debt management could be improved and our recommendations remain unimplemented. We also recommended eliminating the backlog in MCCF billings, increasing accuracy of medical recommendation and coding, and more aggressively pursuing receivables as ways VA could enhance MCCF collections, which totaled $3 billion from FY 1997 through

2001. As of September 30, 2004, almost $235 million of overpayments in C&P and education benefits were uncollected.

We have reported on VA's need for an integrated financial management system as far back as the audit of VA's FY 1991 financial statements. We reported this issue as a long-standing material weakness in our FY 2004 Financial Statement Audit. VA's current Financial Management System (FMS) and numerous legacy systems interfacing with it, such as the Integrated Funds Distribution Control Point Activity Accounting and Procurement (IFCAP), have limited capability to share information and are expensive to maintain.

The quality, accuracy, and usefulness of financial data remain an ongoing high-priority issue to OIG. Of the major indicators used to measure the Department's performance, we found six of the seven we measured to date contained invalid data. VA has corrected these six systems. We will continue to emphasize data integrity, elimination of redundant data, and standardized procedures for ease of use of data. Reliable, timely information on the cost of VHA, VBA, and NCA programs is essential to facing the challenges of administering these programs for the maximum benefit of veterans in the upcoming years.

We will continue to review and make recommendations to improve the effectiveness and efficiency of VA financial management with the goal of making VA operate in a more businesslike manner. While addressing current and future financial management challenges, we will continue to identify best business practices aimed at helping VA achieve its financial management goals.

STRATEGIC GOAL #3 — Financial Management

Assist VA in achieving its financial management mission of providing all VA activities with accurate, reliable, and timely information for sound oversight and decision making; and identify opportunities to improve the quality, management, and efficiency of VA's financial management systems.

PERFORMANCE GOALS:

1. **Maintain unqualified ("clean") audit opinion on financial statements.**
2. **Eliminate material weaknesses and reportable conditions.**
3. **Ensure compliance with all applicable laws and regulations.**
4. **Implement a working, fully-integrated financial management system that provides timely, accurate, and useful information for informed management decisions and ongoing accountability.**
5. **Ensure data validity in financial management systems.**
6. **Strengthen internal controls over transaction processing systems.**
7. **Reduce erroneous and fraudulent payments.**
8. **Improve debt management.**
9. **Increase medical care collections and accuracy of billings.**
10. **Improve financial reporting.**
11. **Reduce financial fraud.**
12. **Link planning, budgeting, and performance with a focus on results.**

Office of Audit:

- **VA's consolidated financial statements.** OA will perform responsibilities as a Contracting Officer's Technical Representative for the contractor audit of VA's Consolidated Financial Statements.
- **Enterprise Fund Office financial statements.** OA will continue to oversee the work of the independent contractor performing the annual financial statements audit of the Enterprise Fund Office.
- **Financial management systems.** OA will continue our audit and related joint reviews to ensure that VA's financial management systems are appropriate, efficient, and useful to management, including any and all replacement systems and supporting integration activities.

- **MCCF debts and MCCF program internal controls.** OA will continue to evaluate the effectiveness of the Department's internal controls over collections activities and related revenues. We will also complete an assessment of the appropriateness of MCCF first party billings and collections for certain veterans receiving C&P benefits.
- **C&P debts.** OA will identify the most significant causes of improper and erroneous overpayments such as processing errors or delays, beneficiary errors, non-compliance with program requirements, and propose remedies to reduce erroneous payments.
- **Cost accounting.** OA will determine whether VA cost accounting systems provide management with reliable and timely information for measuring program performance and product costs.
- **Federal accounts receivable.** OA will conduct a short-term evaluation to enable staff to significantly increase collections, which initial estimates show could increase by over $24 million per year, by aggressively pursing the collection of Federal accounts receivable.
- **Mortgage Loan Accounting Center (MLAC) internal controls.** OA will conduct an audit to assess internal controls and test the accuracy of payment processing. In FY 2004, MLAC made almost 200,000 payments totaling $1.4 billion in consolidated processing of VA's annual payments for the guaranteed loan program.
- **Travel card program internal controls.** OA will conduct a national audit on the use of travel cards by VA employees. During FY 2004, VA employees charged $52.4 million to their Government travel cards. Other agency reviews have found misuse of these cards for personal expenses as well as unnecessary bank fees for late payments on bills and cash withdrawals.
- **VA purchase card rebate program.** OA will review the rebate program as well as the other purchase card internal controls. From 1996 through 2004, rebate revenues from the VA's purchase card contractor to VA totaled approximately $105 million.
- **Grants program.** OA will conduct a national review of the efficiency and effectiveness of the VA grants program. The VA grants program provides funding to states for cemeteries, extended care facilities, and community based programs for homeless veterans. For FY 2005, VA plans $32 million for cemeteries, $100 million for state home facilities, and a legislative proposal is requesting $100 million for the homeless providers and per diem program.
- **Fee-basis third party billing.** OA will survey this issue during CAP reviews and, if warranted, conduct a national audit.

- **Accrued Services Payable (ASP)/Undelivered Orders (UDO) internal controls.** OA will conduct a review to determine whether sufficient internal controls exist to ensure required reviews are conducted, especially at the end of the fiscal year. ASPs are funds obligated for various services and UDOs represent obligations for goods to be delivered; both are to be delivered by a specific date. Monthly and annual reviews of obligations are required to ensure validity. One issue we will focus on is concern that VA medical facilities may have set up fraudulent obligations prior to the close of the fiscal year to set aside prior year monies to charge open obligations.
- **Budget process.** OA will evaluate the VA budget process to determine if the financial management systems provide the information needed to record budget execution for VHA's budget appropriations for medical services, medical administration, medical facilities, and medical and prosthetic research. We will also evaluate if the financial management systems provide information needed to monitor the effectiveness of budget execution in relation to the VA's goals and objectives set forth in its Strategic and Annual Performance Plans.
- **E-travel support system.** OA will continue to review the Department's E-travel implementation efforts, as well as the development of other new electronic system development efforts, to identify best practices that can be applied to these systems.
- **First party debts billings and collections.** OA will review this issue to determine the appropriateness of MCCF first party billings and collections for certain veterans receiving compensation and pension benefits.
- **Payroll issues.** OA will review the efficiency and effectiveness and the adequacy of controls over pay administration. These efforts will include evaluation of selected payroll issues, such as accruals, payroll deductions, special and premium pay considerations, overtime, and payments to fictitious employees.
- **Supply inventories controls.** OA will review and evaluate supply inventory control issues such as write-offs, nonexpendable equipment, and real property inventories.
- **Capital investment policy.** OA will review and evaluate VA capital investment policies to ensure compliance with legal requirements, and increase efficiency and effectiveness.
- **Payment processing control issues.** OA will review and evaluate payment processing issues not otherwise included in the projects summarized above, such as credit cards, cash controls, duplicate payments, third party payments, electronic fund transfers, out-of-system payments, fee-basis medical care payments, and unliquidated obligations.

- **Debt management and collection control issues.** OA will review and evaluate debt management and collection issues not otherwise included in the projects summarized above, such as recovery of advances, vendor receivables and offsets, inter-agency reimbursements, and intra-agency and appropriations reimbursements.
- **Single audit oversight.** OA will monitor single audit requirements impacting VA pursuant to OMB Circular A-133.
- **Data validity.** OA will continue our ongoing data validity work to ensure that VA has reliable data for all purposes, but especially for financial reporting and management decision-making purposes. We will review selected aspects of data validity focusing on addressing the Department's mission-critical performance indicators. We plan to integrate evaluation of data validity into future audits, evaluations, investigations, and especially CAP reviews.

Office of Investigations:

- **Financial fraud.** OI will aggressively investigate and pursue prosecution of allegations of financial fraud, and will conduct proactive programs to identify erroneous and fraudulent payments, with an emphasis on both prosecuting wrongdoing and identifying for correction systemic weaknesses in VA systems and operations which contributed to criminal activities. Such proactive programs include the Fugitive Felon Program, which identifies and apprehends fugitives from justice whom VA subsidizes through ongoing benefits payments; the International Benefits Reviews, which identify fraudulent receipt of VA benefits overseas; the Death Match Program, which identifies payment made to deceased beneficiaries; the IVM match, which identifies payment of income-based pensions made to beneficiaries earning above the income threshold, and other similar proactive programs.
- **Purchase card fraud.** In FY 2004, VA employees made 3.6 million commercial purchase card transactions worth $1.9 billion. OI will review records of VA purchase card activities for suspicious acquisitions and other purchases and initiate investigations as appropriate.
- **Fraud awareness.** OI will conduct fraud integrity awareness briefings and act as liaison to ensure that VA officials are aware of the types of crimes occurring and the proper procedures for referring allegations of fraud involving VA financial management systems to the OIG.

PERFORMANCE MEASURES:

Outputs

- Issue 40 reports that identify opportunities for improvement and provide recommendations for corrective action, including annual audit of VA consolidated financial statements.
- Identify best practices.
- Conduct follow-up to ensure implementation of OIG recommendations.
- Conduct customer satisfaction surveys on every OIG project.
- Contribute to 132 arrests, indictments, and informations in criminal investigations.
- Conduct fraud awareness briefings.

Interim Outcomes

- Prompt implementation of OIG recommendations.

  Measures:

  ✓ VA implements 90 percent of new recommendations within 1 year.

  ✓ VA implements 100 percent of past and new recommendations within 3 years.

- Improved efficiencies in VA's operations.

  Measures

  ✓ Legislative, regulatory, policy, practice, and procedural change in VA (e.g, change VA practice not to charge interest on overpayments to veterans).

- Professional, competent, and credible reputation.

  Measure:

  ✓ OIG is rated 5.0 on a scale of 1 - 5 (5 is high) in customer satisfaction survey results from all our internal and external customers (e.g., VA management and staff, U.S. Attorneys, etc.).

- Comprehensive review of data validity.

  Measure:

  ✓ Number of systems reviewed.

- Minimize the impact of criminal activity, fraud, waste, and abuse on VA financial management programs and operations.

  Measures:

  ✓ At least 87 percent of criminal prosecutions and administrative actions against individuals and companies are successful.

  ✓ Monetary impact of OIG criminal and strategic actions, including fines, penalties, restitutions, civil penalties, recoveries, efficiencies, funds put to better use, and cost avoidance is $59 million.

Long-Term Outcomes

- Elimination of $2.2 billion in erroneous payments.
- One integrated financial management system implemented throughout VA.
- All VA financial management systems achieve 100 percent data validity certification.
- Unqualified ("clean") audit opinion of financial statements containing no material weaknesses or reportable conditions.

LINKAGE TO VA AND GOVERNMENTWIDE GOALS AND OBJECTIVES:

- **VA Strategic Plan:** The OIG strategic goal #3 will assist VA in its enabling goal through improving overall governance and performance by applying sound principles, ensuring accountability, and enhancing the management of resources. In addition, OIG strategies, performance goals, and performance measures directly contribute to VA's performance measure of maintaining a clean financial audit with no audit qualifications. Our major projects include the development of an integrated financial management system, data validity, and medical care collections.
- **President's Management Agenda:** The OIG strategic goal #3 furthers the President's third Governmentwide Initiative, Improved Financial Performance. Our strategies, performance goals, and performance measures directly contribute to improving timeliness, enhancing usefulness, and ensuring reliability of VA financial systems, as well as reduction of erroneous payments by VA. In particular, OIG

is integral to VA maintaining clean financial statement audits. OIG also contributes to the fifth Governmentwide Initiative, Budget and Performance Integration, by improving VA's financial management systems, timeliness, accuracy, and reliability of financial information available to VA managers to make decisions that directly improve results and performance.

- **Major Management Challenges:** The OIG strategic goal #3 is directly linked to VA's Financial Management and Reporting challenge, Debt Management, and Data Validity challenges. OIG strategies, performance goals, and performance measures contribute to monitoring and assessing the effectiveness of the implementation of the fully-integrated financial management system; assisting VA's efforts to enhance its debt management; and independently corroborating VA data validity. We have recommended that VHA could enhance MCCF collections by requiring VISN and VAMC directors to strengthen procedures and internal controls for means testing, billing, and collections; reduce the rate of coding and billing errors; decrease the time it takes to bill for services; and improve medical record documentation for billing purposes.

Strategic Goal #4 – Procurement Practices

BACKGROUND:

VA engages in complex, diverse, and widespread procurement activities. With over $6 billion estimated for FY 2005 expenditures for supplies, services, construction, and equipment, VA is one of the largest procurement and supply entities in the country. VA's Office of Acquisition and Materiel Management (OA&MM) operates and maintains an extensive supply system for the Department and its external customers. Internal stakeholders and partners include the Department's Administrations (VHA, VBA, and NCA) as well as VA staff offices. External stakeholders include veterans and their families, Congress, OMB, General Services Administration, Government Accountability Office, and the Departments of Defense, Health and Human Services, Justice, and other Government agencies.

OA&MM conducts national acquisition activities from VA Central Office, Washington, DC, and the National Acquisition Center (NAC), Hines, IL. In addition to procuring supplies and services for VA use, OA&MM awards and administers the Federal Supply Service (FSS) schedules for pharmaceuticals, medical/surgical supplies and equipment, and health care services for the entire Federal Government and other entities authorized to use the schedules. OA&MM works with DoD, VHA, and other Government agencies to identify opportunities and implement strategies for sharing supplies, equipment, space, services and other resources to eliminate redundancy and leverage the buying power of the Federal Government. Each VA Administration also engages in independent contracting and purchasing activities. Although VA's Chief Procurement Executive issues warrants, the vast majority of warranted contracting officers are not employed or directly supervised by OA&MM officials. In addition to being responsible for the majority of VA's purchases, contracting officers award and administer local and regional contracts for supplies, services, and major and minor construction.

To accomplish its mission and meet its business goals, VA must identify and deploy acquisition strategies that meet the needs of the customer by providing the right product at the right time to the right person at the right price while maintaining the integrity of the acquisition program and complying with statutory and regulatory requirements. OA&MM has identified five major business goals: implementing an effective customer relationship management program, growing the business, improving business operations, enhancing OA&MM's statutory and regulatory role, and creating a paperless OA&MM environment.

The challenge for the OIG is to develop and implement an effective plan to conduct oversight of VA's widespread and diverse acquisition activities and provide VA management with findings and recommendations that will improve the efficiency and effectiveness of the acquisition program. Routine reviews of acquisition activities; audits and investigations of individual contracts, purchases, and contracting activities conducted

in response to complaints and concerns received from third parties; and proactive audits, reviews, and investigations of local and national procurement activities comprise OIG's oversight strategy.

OIG CAP reviews include routine reviews of acquisition activities at VHA medical facilities and network offices, and at VBA's regional offices. These reviews include assessments of all aspects of the procurement process including acquisition planning, contract award, and contract administration. In addition to providing findings and recommendations to each facility, findings from all facilities are compiled and analyzed to identify issues that are local and those that are systemic. At least annually, VA management officials are provided a comprehensive report identifying strengths and weaknesses in the acquisition process with recommendations to improve the efficiency and effectiveness of the system. Aggregate findings from CAPs and reactive reviews also provide the basis for a national audit or review of specific issues. As one example, CAP reviews identified significant vulnerabilities with the increase in, and decentralized use of, the Government credit cards as an acquisition tool. These findings were compiled and a report issued to the Department with recommendations.

The OIG Contract Review and Evaluation Division conducts reviews of acquisition practices through a Memorandum of Understanding (MOU) with VA. In FY 1993, OA&MM and the OIG entered into an MOU under which the OIG conducts preaward and postaward reviews of FSS proposals and contracts. In the past 10 years, the preaward reviews have resulted in $1.1 billion in Better Use of Funds (BUOF) of which $788 million (74 percent) was sustained during contract negotiations. Postaward reviews resulted in more than $220 million in recoveries, most of which was returned to VA's Supply Fund. The oversight has made the contracting community more accountable for providing accurate, complete, and current information during contract negotiations and complying with contract terms and conditions. One result is the significant increase in voluntary disclosures by industry. Prior to FY 1993, VA had received only one voluntary disclosure. Since the inception of this program, VA has received 94 voluntary disclosures offering $37 million in refunds for overcharges. The amount recovered as a result of the voluntary disclosure reviews of the $220 million recovered totaled $116 million. These reviews provide insight into commercial acquisition practices as well as purchasing practices of VA and the impact on VA's ability to leverage the Government's buying power to obtain pricing that is equal to or better than most favored customer and recover overcharges.

In 1996, Congress passed the Veterans Health Care Eligibility Reform Act, which contains provisions that allow VA to further streamline the procurement of health care resources and expanded VA's authority to enter into sharing agreements to buy and sell health care resources. The legislation specifically allows VA to enter into sole-source agreements with affiliated institutions. As a result of the legislation, there has been an increase in contracts to purchase health care services to provide

medical care at VA facilities. In FY 2000, VA issued a policy requiring preaward reviews by the OIG of sole-source proposals with a total value of $500,000 or more. Since the inception of this policy, the OIG has completed 72 preaward reviews that resulted in $24.9 million in recommendations for BUOF. Of the 72 reviews completed, 54 contracts were negotiated and awarded through December 31, 2004. In the 54 reviews, we recommended $16.4 million in BUOF, of which $10.2 million (62 percent) was sustained during contract negotiations. Findings obtained during these reviews and those conducted during CAPs were compiled and provided to VHA in a comprehensive report with recommendations for improving the process of purchasing health care services. VHA has concurred in the recommendations and developed new policy. In future reviews, we will evaluate if changes made in response to our recommendations have improved the efficiency and effectiveness of the program.

OIG also conducts audits, reviews, and investigations of local and national contracts in response to requests from the Secretary, the Congress, and individual complainants. For example, in FY 2004, at the request of the Congress and the Secretary, the OIG conducted an extensive review of the award and administration of task orders for the procurement of integrator services of a $472 million consolidated financial and logistics management system that was intended to standardize the processing and collection of VA financial and logistics data collection. The review showed that deficiencies in the award and administration of the task orders and the project in general resulted in the loss of millions of dollars on a system that was not functioning properly and affecting patient care. As a result of the significant deficiencies and vulnerabilities in the planning, award and administration of the consolidated financial and logistics management system and another travel system project that is the subject of an ongoing review, the OIG is conducting a comprehensive audit of Central Office Acquisition Services.

Another significant portion of OIG activities relating to procurement are the criminal and administrative investigations conducted in response to complaints received through the OIG Hotline and from other Government agencies, including the Department of Justice. The violations alleged in these cases include false claims, false statements, fraud, antitrust, and anti-kickback violations, violations of the Buy America and Trade Agreements Acts, theft, and violations of Federal conflict of interest statutes. In addition to obtaining arrests and convictions, recovering overcharges, and recommending administrative action against employees and contractors who engage in these activities, these investigations identify strengths and weaknesses in the system which the OIG provides to VA management with recommendations to improve procurement processes and thus prevent similar activity from occurring in the future.

STRATEGIC GOAL #4 – Procurement Practices

Ensure that VA's acquisition programs support our Nation's veterans, other Government entities, and the taxpayer by providing its customers with quality products, services, and expertise delivered in a timely fashion, for a reasonable price, and to the right place.

PERFORMANCE GOALS:

1. **Ensure that the organizational structure and leadership responsible for VA's procurement programs are aligned to meet the mission and needs of VA and other Government customers.**
2. **Ensure that VA procurement programs and processes are results oriented, provide effective internal controls, and evidence adequate contract management.**
3. **Ensure that VA contract solicitations, awards and administration, and purchasing actions comply with statutory and regulatory provisions and internal VA policies, demonstrate adequate procurement planning, meet the needs of the customer, and protect the interests of the Government.**
4. **Ensure that VA has the appropriate human capital invested in its procurement programs to meet VA's missions and goals and the workforce is properly integrated and aligned within VA.**
5. **Ensure that individuals within the procurement process are held accountable for taking procurement actions that fail to meet the needs of the customer or to protect the interests of the Government.**
6. **Ensure a focus on the identification and prevention of fraud, theft, bribery, antitrust, and other civil or criminal violations that may be associated with the procurement processes and functions.**

7. **Ensure that VA identifies and collects overpayments.**
8. **Ensure that VA identifies and implements business practices that will result in cost savings, improve the quality of VA's procurement programs, and ensure customer satisfaction.**
9. **Ensure that the Government procures value in terms of quality and price.**

Joint Projects:

- **CAP reviews.** OIG will continue to review procurement and purchasing practices and VA medical centers and VBA regional offices during CAP reviews, including human capital issues of training and deployment of staff.
- **Contract reviews.** OA and OI will conduct reviews and investigations of local and nationally awarded contracts proactively and in response to complaints to identify any criminal activity in the following areas: anti-trust violations, bid-rigging, bid-rotation, false claims, product substitution, Buy America and Trade Agreement Acts violations, bribery, and conflict of interest violations. When appropriate, we will refer matters through OI to the Department of Justice for prosecution and make appropriate and timely referrals to VA for suspension/debarment.

Office of Audit:

- **Preaward reviews.** OA will conduct preaward reviews of FSS proposals for pharmaceutical contracts valued at $25 million or more, of medical/surgical supplies and equipment valued at $15 million or more, health care services, and of proposals valued at $500,000 or more for contracts to be awarded on sole-source basis to VA affiliated institutions to provide health care resources. Each review will provide the Contracting Officer with recommendations and strategies for negotiating best prices.
- **Postaward reviews.** OA will conduct proactive and reactive postaward reviews on FSS contracts to identify and collect overpayments by VA and other Government agencies that result from overcharging, defective pricing, and violations of the price reduction clause. Reactive reviews include those conducted in response to voluntary disclosures, civil actions filed pursuant to the qui tam provisions of the False Claims Act, and complaints received through the OIG Hotline. When appropriate, referrals will be made

to the Department of Justice and to the appropriate suspension/debarment official.

- **Proactive audits of national contracting programs.** OA will conduct proactive audits and reviews of national contracting programs based on information obtained from surveys, risk assessments, preaward and postaward reviews, reactive audits, reviews, investigations, and knowledge of VA procurement programs. Programs include major construction; durable medical equipment; procurement of clinical services (local and FSS); information technology hardware and software; prosthetics; subsistence; revenue generation activities (e.g., selling health care services, leasing space, contracting and purchasing on behalf of other Government agencies, etc.); purchase, distribution, and dispensing of pharmaceuticals; VA/DoD sharing initiatives and opportunities; compliance with small business initiatives; and compliance with Government outsourcing initiatives.
- **VHA construction contract award and administration.** OA will complete an assessment of the effectiveness and efficiency of VHA's construction contract awards and administration.
- **E-travel support services.** OA will complete an assessment of VA's efforts to implement an E-travel system solution that meets VA requirements and user needs in an efficient and effective manner. We will also assess the extent to which this effort duplicates, overlaps, or conflicts with other Federal E-Government program initiatives.
- **VA procurement activities for other Government agencies.** OA will audit whether VA contracting services performed for other Government agencies are being conducted effectively, efficiently, and in accordance with applicable laws and regulations.
- **Energy conservation.** OA will complete its audit of VA's compliance with the National Energy Conservation Act of 1978 and Executive Order 13123.
- **Vocational Rehabilitation and Employment (VR&E) contracts.** OA will complete an assessment in response to information OIG received regarding potential problems with the pricing of the national contracts supporting VR&E service requirements.
- **VA Central Office procurement activities.** OA will complete an audit of the effectiveness and efficiency of VA Central Office procurement activities. We will examine phases of the contracting process including procurement planning, awards, administration, and oversight to determine if contracting actions were conducted in an efficient and effective manner.
- **VHA's acquisition of medical transcription services.** OA will complete an audit that will determine if VHA's transcription services are acquired economically, efficiently, and in compliance with applicable requirements. We are examining alternative approaches

to acquiring these services to yield better program performance or eliminate factors that inhibit the delivery of effective services.

- **Information technology contracts.** OA will audit the effectiveness and efficiency of selected VA information technology contracts. We will examine phases of the contracting process including procurement planning, awards, administration, and oversight to determine if contracting actions were conducted in an efficient and effective manner.
- **Alleged mismanagement of national Vietnam veterans longitudinal study.** OA will complete an assessment of allegations of mismanagement of the congressionally-mandated study to determine whether this study produced the intended results.
- **Medical oxygen contract and supply management.** OA will assess the effectiveness of medical bulk oxygen contract administration and related supply management issues to prevent unwarranted disruption of activities and functions within this vital healthcare services support system.
- **Purchase cards.** Primarily through CAP reviews, OA will identify strengths and weaknesses in the use of the purchase card. Areas of concentration include: implementation of management controls to identify and prevent misuse of the credit card, open market purchases, purchasing from mandatory sources, splitting orders to avoid competition requirements, theft, and conflict of interest violations. We will compile and analyze the data to identify patterns of practice that reflect strengths and weaknesses that affect local procurement and purchasing practices and report findings to VA management with recommendations to improve the efficiency and effectiveness of the programs.
- **Best practices.** OA will monitor and analyze the results of preaward, postaward, CAP, and contract reviews to identify patterns and practices and periodically report to VA management best practices and deficiencies, and provide recommendations to achieve a more efficient and effective acquisition process. For example, we will continue to monitor implementation of the recommendations made in 2002 by the VA Procurement Reform Task Force, including product standardization, use of national contracts, and the development of national contract vendor and product listings.

Office of Investigations:

- **Hotline complaints and other allegations.** OI will investigate complaints alleging fraud, mismanagement, and criminal activity in the procurement and delivery of services and materials, and the oversight of VA contracts, including fraudulent acts involving credit card misuse, contacts, and procurement by VA employees or contract agents.

- **Construction fraud.** OI will investigate complaints of fraudulent or criminal activity in construction contracts, and refer substantiated allegations to appropriate authorities for criminal prosecution or administrative action.
- **Fraud awareness.** OI will conduct fraud integrity awareness briefings and act as liaison to ensure that VA officials are aware of the types of crimes occurring and the proper procedures for referring allegations of fraud or criminal activity involving VA procurement practices to the OIG.

PERFORMANCE MEASURES:

Outputs

- Issue 400 preaward and postaward reviews of FSS, prime vendor, and health care resource contracts with recommendations in preaward reviews to contracting officers for better use of funds.
- Establish $3.4 billion in monetary benefits, e.g., better use of funds, collection of overcharges, etc., that occurred due to pricing errors and defective pricing and price reduction violations, and other conditions identified in audit reports and reviews.
- Include relevant procurement practices review areas in 409 CAP reviews (including CAP summary reports) and complete a cycle of VHA and VARO CAPs.
- Issue 25 audits or reviews on procurement practices that identify opportunities for improvement and provide recommendations for corrective action.
- Conduct customer satisfaction surveys on every OIG project.
- Conduct follow-up to ensure implementation of OIG recommendations.
- Contribute to 528 arrests, indictments, and informations in criminal investigations involving procurement practices.
- Conduct fraud awareness briefings.
- Identify and disseminate VA best practices in procurement that will improve VA operations through report recommendations.

Interim Outcomes

- Improved procurement processes.

  Measures:

  ✓ Evidence of adequate and purposeful acquisition planning.

- ✓ Solicitation will be accurate and complete and contain terms and conditions that will protect the interests of the Government.
- ✓ Evidence of adequate competition.
- ✓ Effective leveraging of Government's buying power to obtain more favorable pricing, terms and conditions, and more efficient use of procurement resources.
- ✓ Compliance with Federal Acquisition Regulations (FAR) and VA Acquisition Regulations (VAAR) provisions to protect the Government's interests.
- ✓ At least 65 percent of preaward review recommendations are sustained during contract negotiations.
- ✓ Increase in ability to collect overcharges relating to defective pricing and price reduction violations.

- Improved purchasing practices.

  Measures:

  - ✓ Comprehensive and effective use of contract sources/ distribution methods.
  - ✓ VA increases use of nationally awarded contracts from established baseline by 50 percent.
  - ✓ VA reduces number of open market purchases from established baseline by 50 percent.
  - ✓ Appropriate and effective use of Government purchase cards.
  - ✓ Timely identification of improper and illegal purchases.

- Improved inventory management practices.

  Measures:

  - ✓ Effective use of prime vendor and just-in-time delivery methods.
  - ✓ Inventories are maintained at the appropriate levels as evidenced by:
    - ❍ VA reduces stock outages from established baseline by 75 percent.

- VA reduces excess and outdated inventory from established baseline by 75 percent.

- VA achieves 95 percent effective use of Generic Inventory Package (GIP) or other automated systems to manage and monitor purchasing, storage, and distribution of supplies and equipment.

- Improved ability to recruit and retain a highly qualified and effective acquisition workforce.

  Measures:

  - ✓ Contracting officers and purchasing agents will be properly warranted and will conduct business within the scope of their warrants.

  - ✓ Warranted contracting officers have received timely, appropriate, and adequate training that enables them to effectively perform the duties and responsibilities of their positions.

  - ✓ Improvement in the recruitment and retention of a strong acquisition workforce.

  - ✓ The number of acquisition personnel is adequate to meet the needs of the Department.

- Improved Organizational Effectiveness.

  Measures:

  - ✓ Timely and effective use of legal/technical and business oversight reviews.

  - ✓ Contracts awarded in a timely and efficient manner.

  - ✓ Contracting and purchasing personnel are properly aligned within VA to enable them to execute their duties and responsibilities effectively and independently.

  - ✓ Timely and effective implementation of and compliance with Procurement Reform Task Force recommendations.

  - ✓ Acquisition workload is properly distributed among the acquisition workforce.

  - ✓ Improved oversight and accountability of contracting and purchasing officials.

- Minimize the impact of criminal activity, fraud, waste, and abuse on VA procurement practices.

  Measures:

  - ✓ At least 87 percent of criminal prosecutions and administrative actions against individuals and companies are successful.
  - ✓ Monetary impact of OIG criminal and strategic actions, including fines, penalties, restitutions, civil penalties, recoveries, efficiencies, funds put to better use, and cost avoidance is $6 million.

- Professional, competent, and credible reputation

  Measure:

  - ✓ OIG is rated 5.0 on a scale of 1 - 5 (5 is high) in customer satisfaction survey results from all our internal and external customers (e.g., VA management and staff, U.S. Attorneys, etc.).

Long-Term Outcomes

- Effective and efficient contracting and purchasing processes that provide the right product to the right place at the right time and at the right price.
- Highly qualified and effective procurement workforce that is able to operate independently, meets the needs of the customer, and complies with the FAR and the VAAR.
- $4.0 billion cost-savings to the Government through improved contracting processes that include:
  - ♦ More economical, efficient, and timely procurements.
  - ♦ Legally and technically sound solicitations, awards, and modifications.
  - ♦ Reduction in the number and monetary value of successful protests and other contract actions against VA.
  - ♦ Selection of the right contractor to provide goods and services.
  - ♦ Effective contract negotiations that result in fair and reasonable prices that reflect effective and efficient contract administration.

- ♦ Reduction in lost monetary recoveries resulting from VA contracting errors.

- Increased acquisition program integrity resulting from efforts to identify and deter illegal and improper acts by contractors and VA personnel.

LINKAGE TO VA AND GOVERNMENTWIDE GOALS AND OBJECTIVES:

- **VA Strategic Plan:** The OIG strategic goal #4 will assist VA through improving their overall governance and performance by applying sound principles, ensuring accountability, and enhancing management of resources through improved capital asset management; acquisition and competitive sourcing; and linking strategic planning, budgeting, and performance planning (VA enabling goal).

- **President's Management Agenda:** The OIG strategic goal #4 supports the President's Governmentwide Initiatives for Improved Financial Performance, and Expanded Electronic Government. Our goals emphasize oversight of VA's acquisition programs resulting in cutting Government operating costs. Our strategies and projects focus on reviewing sole-source contract awards and contract proposals. These reviews are critical to controlling costs and improving the performance of VA programs. Our planned outcomes include increased effectiveness in leveraging of Government's buying power to obtain more favorable pricing, terms, and conditions, and more efficient use of resources.

- **Major Management Challenges:** The OIG strategic goal #4 assists VA directly with its Major Management Challenge in Procurement. Our strategies and projects focus on FSS contracts, contracting for health care services, Government purchase card activities, and inventory management.

Strategic Goal #5 – Information Management

BACKGROUND:

Along with the entire Federal Government and society at large, VA is becoming increasingly computer-based. The centrality of information technology (IT) in VA's future is nowhere more evident than in VA's 2003-2008 Strategic Plan, which states that the Internet is seen as the primary communication vehicle VA has with its customers. Every month, more veterans receive their VA benefits through electronic direct deposit rather than a paper check. Every day, veteran patient medical records and treatment information are accessed and entered electronically at thousands of networked computer terminals. VA maintains insurance, health, and burial records in millions of computer files. In its FY 2004 Performance and Accountability Report, VA stated that all VAMCs had provided their patients with electronic access to their DoD health care records. Annually, VA processes millions of transactions worth over $40 billion, and these figures will continue to increase. In FY 2004, for example, VA paid 84 percent of VBA benefits worth almost $30 billion through 34.7 million electronic transactions.

VA faces major challenges to leverage the full potential of IT, particularly the Internet and VA intranet, to improve performance, cut costs, and enhance access and responsiveness to employees, veterans, other stakeholders, and the public. These challenges include:

- IT development and capital investment decisions.
- Acquisition and deployment of IT assets.
- Information collection.
- Records management.
- Paperwork reduction.
- Statistical and workload compilations.
- Data integration.
- Systems training.
- System interoperability.
- Sharing and dissemination of information.
- Privacy and security of the information it manages.

OIG's efforts will concentrate on assisting VA in using information effectively, maintaining patient safety in using information in patient care, efficiently utilizing IT resources, assuring interoperability among systems, ensuring security of information, and prevention of misuse or criminal activity involving IT systems. The impact of these efforts will contribute to each of the other four strategic goal areas.

As of FY 2004, VA uses 684 support systems and major applications, many of which contain sensitive information. Information systems security has been identified as a material weakness as early as 1998. Almost all VA employees use IT technology on a daily basis to perform their mission-critical duties, as well as for support functions such as leave requests and payroll deductions. All major VA activities – from filling prescriptions, to ordering supplies, to issuing benefits payments, to paying employees – involve interactive information management.

VA continues to face significant challenges because many of its IT systems remain independent and serve limited, parochial interests. VA-wide, these areas have suffered from multimillion-dollar cost overruns, schedule slippage, and disappointing results. VA has established the goal of a unified veterans' centric IT framework that supports the integration of information across Administrations, staff offices, and business lines and that provides consistent, reliable, accurate, and secure information to its users. OIG oversight has demonstrated that this goal has not yet been achieved. Independent systems still operate in all three Administrations.

The potential vulnerability of Federal information systems cannot be overestimated. Presently, VA systems are not protected from unauthorized access. Risks of potential disclosure or loss of sensitive data, fraudulent claims, and disruption of critical activities remain. Security over VA IT resources needs to assure that only authorized users access VA resources and only authorized use is made of VA resources. Legal requirements such as the Privacy Act, the Federal Information Security Management Act of 2002 (FISMA), and the Health Information Portability and Accountability Act of 1996 (HIPAA), impose detailed duties on VA to protect sensitive medical and personal information it maintains on veterans, their families, and its employees. OIG recognizes the frustration among VA managers and staff that the mandated privacy and security restrictions often work at cross purposes with the technical capabilities of IT. Nevertheless, the rules must be followed. OIG considers IT security one of its highest priority concerns over the next 6 years.

While computers and networks have improved timeliness and accuracy of certain services, VA must appreciate that every computerized/electronic transaction is as susceptible to fraud and criminal activity as manual transactions of years past. Identity theft is the fastest growing type of crime today, and veterans receiving VA benefits, especially the elderly or disabled, are vulnerable to criminal predators. Every VA automated transaction is subject to misuse and criminal attack. Through an aggressive investigative posture and systematic audit oversight work, OIG will assist the Department in making risk assessments, developing local and national security plans, securing access to IT equipment from unauthorized users, certifying system security, and holding violators accountable.

The popular maxim "garbage in, garbage out" has for decades denoted that IT systems produce reliable, accurate output only when attention

is paid to quality control over data input. IT impacts all phases of VA operations: planning, budgeting, performance measurement, and reporting. Numerous data collection systems produce data that VA report as required as GPRA results. OIG work has raised serious data validity concerns; thus, VA's plans and results have been detrimentally affected by faulty data concerning medical care, benefits, and education programs.

The cost and commitment to upgrade and integrate IT systems is a substantial part of the VA budget and will continue to rise rapidly in the years ahead. Combined VA expenditures total about $1 billion annually. OIG will continue close oversight of the extensive IT acquisition and implement activity, as this area involves such monumental impact on overall VA performance and mission accomplishment. VA must remain flexible to adapt its huge IT infrastructure to emerging technologies.

VA has no choice but to move forward in the IT realm. Legacy systems are expensive for VA to maintain and may not adequately satisfy VA's future processing and interoperability requirements. Patch management is also an issue, as many security patches cannot be applied to some legacy systems. OIG will continue to test VA IT systems for vulnerabilities, investigate complaints of wrongdoing or service denials involving IT systems, and make recommendations to promote effectiveness and efficiency in VA's programs and operations.

STRATEGIC GOAL #5 – Information Management

Assess information systems within VA to determine that they are adequately managed and protected to ensure information availability, integrity, authentication, and confidentiality; used in a lawful and ethical manner; are cost effective; and meet the needs of the user/customer. Investigate fraud and other computer related crimes against the VA.

PERFORMANCE GOALS:

1. **Assist VA to comply with the requirements of the FISMA.**
2. **Assist VA in eliminating information security as a material weakness.**
3. **Ensure compliance with all applicable information security laws and regulations.**

4. **Improve VA's critical infrastructure protection planning and implementation, and ensure continuity of operations and delivery of services to the Nation's veterans.**
5. **Eliminate the serious security vulnerabilities that have continued to exist over a multi-year period.**
6. **Improve VA's information security posture and reduce risk for disruption of mission critical systems, unauthorized access and improper disclosure of data, fraudulent benefit payments, and fraudulent receipt of health care benefits.**
7. **Ensure VA systems comply with HIPAA.**
8. **Ensure data validity in VA IT systems.**
9. **Ensure that all new IT systems include necessary security controls.**
10. **Improve the effectiveness of acquiring, designing, and implementing IT systems.**
11. **Improve the interoperability between VA systems and with other Federal agencies.**
12. **Ensure that mission critical IT applications effectively meet VA user needs.**
13. **Reduce inappropriate use of data and information management resources (i.e., identity theft), and eliminate unlawful access and use of Department information systems.**
14. **Ensure that computer system crimes are investigated.**

STRATEGY/PROJECTS:

Office of Audit:

- **FISMA.** OA will continue this mandated work with the focus on continuing to improve VA's information security posture and assist VA in eliminating information security as a material weakness area. One of the methods to determine the security of networks is by use of penetration testing. OA will assess the effectiveness of information security controls in VA systems by conducting penetration testing at

local and network facilities. Work will help ensure our information and information systems are safeguarded and help detect and prevent unauthorized access and release of privacy information.

- **Security risks.** OA will continue coverage of significant IT security risk areas as part of the OIG's CAP reviews. This will provide further assurance that security protections required by VA policy are put into action at the field level.
- **Firewall.** OA will evaluate VA's firewall policy and the effectiveness of its implementation to determine if proper security settings are in place to detect, prevent, or correct security vulnerabilities of the existing firewall(s). We will also evaluate:
  - The administration and control of the firewalls to ensure that controls are in place to protect the network.
  - Access controls to the firewalls.
  - Filters and conditional filter handling on the firewall.
  - Performance, such as capacity or throughput, of the firewall.
  - Virus and worm protection.
  - Transmission Control Protocol/Internet Protocol services to determine how they are used/restricted.
  - Intrusion detection of the network.
- **System development life cycle.** OA will assess VA's life-cycle management process for determining the need, development, implementation, and retirement of the Department's information technology assets.
- **Legacy systems transition.** OA will conduct a national audit of VA's planning and implementation efforts for transition from legacy systems in support of the one VA architecture.
- **Compensation and Pension Evaluation Redesign (CAPER).** OA will conduct an audit of the effectiveness and efficiency of VA's implementation of this key IT initiative. The CAPER project is a complex IT initiative that will integrate various applications to support VA's disability examination process and a rules-based rating process.
- **Wireless network security review of VA.** OA will assess the effectiveness of VA's wireless network security policy as part of the Consolidate Financial Statement audit, ensuring resources are safeguarded against unauthorized acquisition, use, or disposition.

Office of Investigations:

- **Computer related crimes.** OI will continue to promote communication and work with VA information security officials, other Offices of Inspectors General, and law enforcement agencies to effectively respond to computer-related crimes. The OIG Computer Crimes and Forensics Program will continue to provide key support in ensuring that computer related crimes occurring in VA are

investigated in a timely manner and those individuals responsible are referred for prosecution and/or for appropriate administrative action.

- **Fraud awareness.** OI will conduct fraud integrity awareness briefings and act as liaison to ensure that VA officials are aware of the types of crimes occurring and the proper procedures for referring allegations of fraud involving VA computer systems to the OIG.

PERFORMANCE MEASURES:

Outputs

- Issue 20 audit reports that identify opportunities for improvement and provide recommendations for corrective action, including the annual FISMA audit.
- Conduct follow-up to ensure implementation of OIG recommendations.
- Conduct customer satisfaction surveys on every OIG project.
- Contribute to 132 arrests, indictments, and informations in criminal investigations.
- Identify and disseminate best practices in information management through report recommendations.
- Conduct fraud awareness briefings.

Interim Outcomes

- Improved effectiveness of VA's information assurance programs to recognize and mitigate threats and vulnerabilities.

  Measure:

  ✓ Identify 100 percent of systems addressing key threats and vulnerabilities.

- Key IT vulnerabilities eliminated through security remediation.

  Measure:

  ✓ Identify 100 percent of systems having revised vulnerabilities.

- Improved performance relative to applicable policy, statutes, and regulations regarding information systems.

Measure:

- ✓ Identify 90 percent of systems in compliance.

- Elimination of information security as a material weakness area for the Department.

  Measure:

  - ✓ Material weakness areas corrected and removed from financial statements audit.

- Improved interoperability between VA systems and with other Federal agencies.

  Measure:

  - ✓ All VA systems fully capable of interoperability with other VA systems and other Federal agencies.

- Improved personnel awareness of data privacy, integrity rules and regulations, and code of ethics.

  Measure:

  - ✓ All VA systems fully compliant with training requirements.

- Professional, competent, and credible reputation.

  Measure:

  - ✓ OIG is rated 5.0 on a scale of 1 - 5 (5 is high) in customer satisfaction survey results from all our internal and external customers (e.g., VA management and staff, U.S. Attorneys, etc.).

- Minimize the impact of criminal activity, fraud, waste, and abuse on information management programs and operations.

  Measures:

  - ✓ At least 87 percent of criminal prosecutions and administrative actions against individuals and companies are successful.

  - ✓ Monetary impact of OIG criminal and strategic actions, including fines, penalties, restitutions, civil penalties, recoveries, efficiencies, funds put to better use, and cost avoidance contributes to each of the other four strategic goal areas.

Long-Term Outcomes

- A centralized IT security program that is fully implemented.
- VA IT systems that are effectively planned, implemented, and managed.
- VA IT systems that meet the needs of the user.
- Reduced fraud and other criminal activities associated with the acquisition and maintenance of information management supplies and service.
- Reduced identity theft and other inappropriate losses of IT resources, as well as unlawful access and use of information systems, data, and IT resources.
- Compliance with all security laws and regulations.

LINKAGE TO VA AND GOVERNMENTWIDE GOALS AND OBJECTIVES:

- **VA Strategic Plan:** The OIG strategic goal #5 will assist VA in delivering world-class service to veterans and their families by applying sound business principles that result in effective management of people, communications, technology, and governance. Our projects support VA's efforts to implement a unified VA information technology framework that supports the integration of information across business lines and that provides a source of consistent, reliable, accurate, and secure information to veterans and their families, employees, and stakeholders (VA enabling goal).
- **President's Management Agenda:** The OIG strategic goal #5 furthers the President's Governmentwide Initiatives for Improved Financial Performance, and Expanded Electronic Government. Our goals emphasize oversight of VA's reliance on technology in all its programs and operations. Information technology is critical to controlling costs and improving the performance of VA programs. While sharing of data and technology among organizations is the goal, and has made service better for veterans, it has increased security risks and the number of issues requiring oversight. Our planned projects and strategies place information security and planning at the forefront of OIG oversight efforts.
- **Major Management Challenges:** The OIG strategic goal #5 assists VA in its Information Management Challenge by focusing its strategies and projects on information security, security of data, data validity, and developing sound agency-wide management strategies to build a high performing organization.

CHAPTER IV

EXTERNAL FACTORS

A variety of factors beyond our control affect the ability to achieve our strategic goals. For example, unplanned requests from external sources can have a significant impact on OIG workload demands, as can reductions in funding or diversion of resources away from critical areas of review due to legislatively mandated requirements. Following is a more detailed discussion of certain external factors that can influence the OIG's ability to fully achieve the goals and objectives set forth in this strategic plan.

Acceptance of OIG Results and Recommendations

It is not within our authority to implement or force the implementation of OIG recommendations, nor can we ensure the timeliness or quality of implementation. While there are processes in place to resolve disputes over recommendations and mechanisms to bring congressional pressure to bear, the ultimate decision to implement OIG recommendations rests with VA program officials.

Likewise, the OIG cannot control the results of judicial proceedings that may affect the outcome of investigative efforts, which affects arrests and indictments. While the OIG conducts the investigations and presents evidence to the U.S. Attorney or other law enforcement authorities for consideration, outcomes, such as convictions, and monetary sanctions, such as fines, penalties, and restitution, are functions of the courts.

Prosecutors may also decline to prosecute cases resulting from our investigations. The judicial system, by its very nature, may result in delays that affect timeliness, and investigations may expand into multi-jurisdictional efforts, which can exhaust resources and protract investigative efforts. Additionally, expanded efforts into long-term, high-priority, high-profile investigative projects can also inhibit our abilities to provide sufficient resources to address each strategic initiative.

Loss of Expertise

As the baby boomer generation matures, attrition of staff due to retirement is a major concern throughout Government. With this attrition comes a loss of corporate knowledge and expertise. While we are proactively engaged in succession planning efforts, recruiting highly qualified employees, especially with information technology expertise, is difficult due to competition from other

Federal agencies and the private sector, which is fueled by a growing economy.

Proactive versus Reactive Work

During the past 10 years, approximately 40 percent of OIG staff available for operational activities was assigned to reactive work resulting from requests from Congress and VA management. In addition, a substantial amount of Investigations and Healthcare Inspections resources are devoted to responding to allegations received by the OIG Hotline. Within Audit, resources are also diverted to reactive work or to fulfilling mandated work, such as the annual audit of VA's consolidated financial statement. Of particular concern is the possibility of additional mandates without providing additional staff to address new requirements.

Reactive and mandated work often demands immediate attention and consumes a large percentage of OIG resources. The challenge in meeting our strategic goals is our inability to predict the extent to which we will have to invest resources in reactive work. Even though we recognize that we will always have to respond to a certain amount of reactive work, we developed a strategic plan based on committing resources to projects aimed at achieving our strategic goals. While we will remain committed to achieving these goals, there exists the possibility of delays due to urgent requests for audits, investigations, and inspections on issues not directly related to our strategic goals.

Legislation

Passage of new legislation that impacts and/or changes the programs or conditions that the VA currently manages will also affect our strategic plan. For example, legislation making veterans' dependents eligible to receive VA medical care, or the granting of service-connection to veterans for a condition prevalent in the veteran population, such as illnesses related to hypertension, obesity or tobacco use, would dramatically increase the number of individuals eligible to receive health care and VA benefits. This would create new demands and challenges for VA in terms of facilities, staffing, funding needs, etc., which in turn would cause us to reevaluate our goals and objectives in terms of what would be the most pressing issues facing VA.

Information Technology

The private sector has achieved significant efficiencies and made notable improvements in how it delivers services through advances in IT. As VA continues to adopt more advanced information technology to improve VA operations and service delivery, concerns about hackers, terrorists, and other criminals gaining access to VA systems will create new challenges and priorities for VA and the OIG. Additionally, updated IT is essential to realizing some of OIG's goals, and in tracking the performance

data necessary to demonstrate the Department's success.

Additional Factors or Changes in the Environment – Foreseen and Unforeseen Situations

The war on terrorism could create a rapid increase in military personnel injuries, which requires refocusing VA medical centers' mission to respond to these needs.

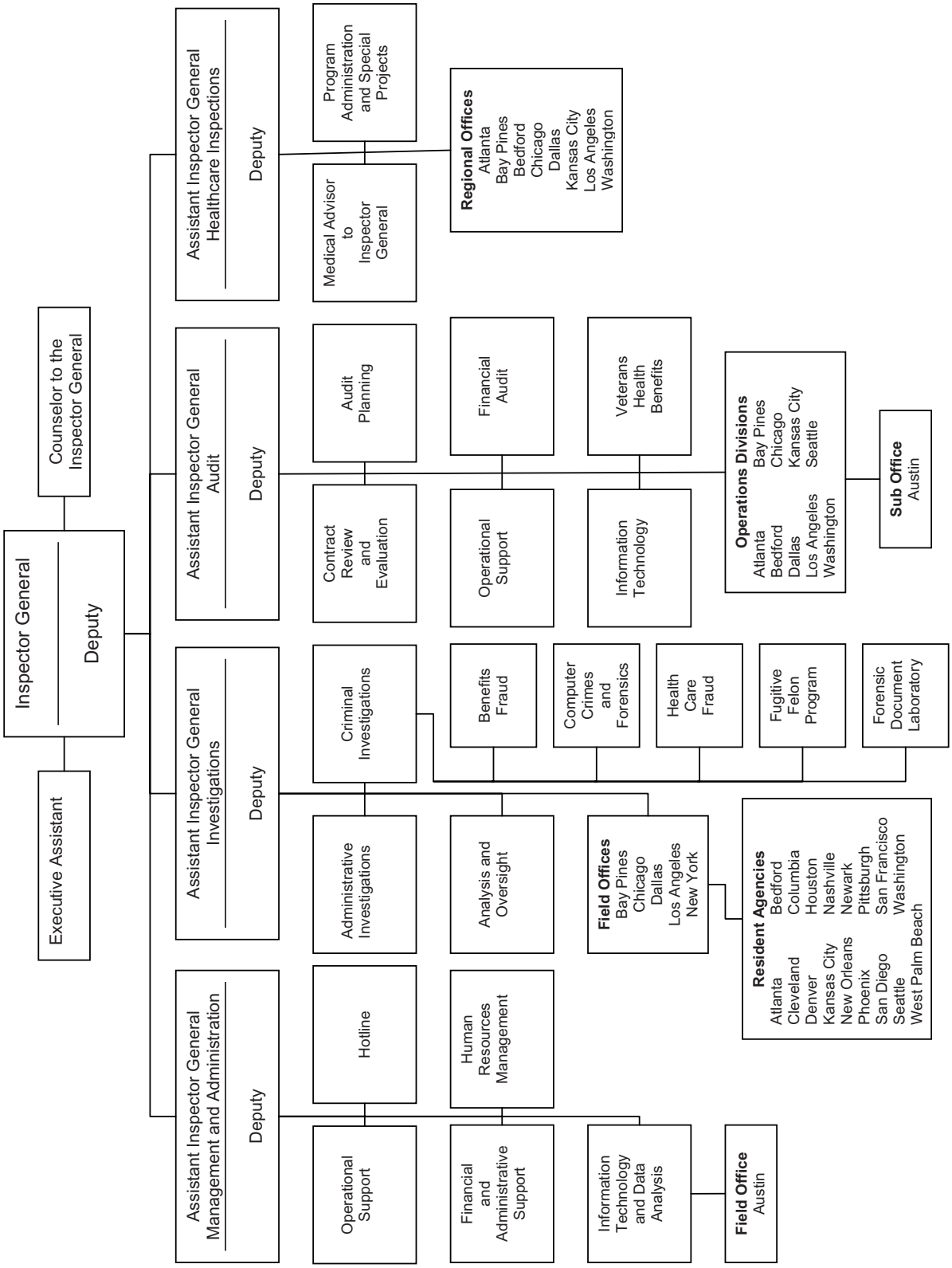
Unpredicted outcomes such as the long-term physical and mental health of military personnel in Iraq, Afghanistan, and other regions or the number and timing of other claims filed by veterans, could increase the demand for VA medical care and benefit resources.

Dramatic advances in medical equipment, pharmaceuticals, communication, and/or information technology could considerably change today's health care practices and, in turn, VA's overall goals and objectives.

To mitigate the impact these factors can have on our success in achieving these goals, we will strive to ensure high-quality work that will withstand administrative and legal scrutiny. We always work to maintain our independence and issue work products that are thorough and objective. Further, we will work with our customers to provide them with work products that are important and useful to them. We will continue to collaborate on crosscutting issues and try to develop recommendations that are meaningful, viable, and supported by management as real time solutions to improving VA activities. If external factors contribute to delays in achieving our strategic goals and objectives, these conditions will be communicated in our annual performance reports.

APPENDIX A

VA OIG ORGANIZATION CHART


Inspector General
Deputy
Counselor to the Inspector General
Executive Assistant
Assistant Inspector General Healthcare Inspections
Deputy
Program Administration and Special Projects
Medical Advisor to Inspector General
Regional Offices
Atlanta
Bay Pines
Bedford
Chicago
Dallas
Kansas City
Los Angeles
Washington
Assistant Inspector General Audit
Deputy
Audit Planning
Financial Audit
Veterans Health Benefits
Contract Review and Evaluation
Operational Support
Information Technology
Operations Divisions
Atlanta
Bedford
Dallas
Los Angeles
Bay Pines
Chicago
Kansas City
Seattle
Washington
Sub Office
Austin
Assistant Inspector General Investigations
Deputy
Criminal Investigations
Benefits Fraud
Computer Crimes and Forensics
Health Care Fraud
Fugitive Felon Program
Forensic Document Laboratory
Administrative Investigations
Analysis and Oversight
Field Offices
Bay Pines
Chicago
Dallas
Los Angeles
New York
Resident Agencies
Atlanta
Cleveland
Denver
Kansas City
New Orleans
Phoenix
San Diego
Seattle
Bedford
Columbia
Houston
Nashville
Newark
Pittsburgh
San Francisco
Washington
West Palm Beach
Assistant Inspector General Management and Administration
Deputy
Hotline
Human Resources Management
Operational Support
Financial and Administrative Support
Information Technology and Data Analysis
Field Office
Austin

APPENDIX B

CUSTOMER SATISFACTION SURVEY FORMS

OFFICE OF AUDIT

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
QUALITY SURVEY

Report Number: _____ **Dated:** _____

Report Title:

Respondent's Name, Title and Location:

Please circle the number which best indicates your opinion of how well the OIG accomplished the following objectives:

OBJECTIVES	Strongly Agree				Strongly Disagree	No Opinion
1. The objectives of this review were important to your office.	5	4	3	2	1	0
2. The review's purpose, scope, and methodology were appropriate and clearly presented to you.	5	4	3	2	1	0
3. The review results were discussed fully with appropriate management personnel.	5	4	3	2	1	0
4. The results of the review were provided to you in a timely manner.	5	4	3	2	1	0
5. The report's conclusions were sound and sufficient information was provided to support the finding(s).	5	4	3	2	1	0
6. The recommendations were relevant and feasible.	5	4	3	2	1	0
7. The report was written clearly and organized logically.	5	4	3	2	1	0
8. Your written response to the draft report was properly considered in finalizing the report, and appropriate changes, where necessary, were made.	5	4	3	2	1	0
9. The report's monetary savings projections, if any, were sound.	5	4	3	2	1	0
10. Members of the review team conducted themselves in a professional manner.	5	4	3	2	1	0
11. The review helped you improve the performance of your operation.	5	4	3	2	1	0

Other: If you have any suggestions to help the OIG improve its service to management or comments about any aspect of this review, please attach them to this survey.

OFFICE OF INVESTIGATIONS

VAOIG file #
Subject(s):

The Office of Investigations is the investigative arm of the Department of Veterans Affairs (VA), Office of Inspector General (OIG). In support of our continuing efforts to improve the quality of our investigations, we ask that you take a moment to answer the following questions. Where a numerical rating is requested, use (1) as the LOWEST and (5) as the HIGHEST and circle the appropriate rating. If you have any comments or suggestions on how we can improve our performance or make your job easier, please let us know. We appreciate the time you have taken to complete this questionnaire. Please mail your response to the address listed below. Thank you.

Was the prosecutive report clear and did it contain evidence to substantiate the allegations?

1 2 3 4 5 N/A

Was the special agent available to assist you in preparation for grand jury or other proceedings?

1 2 3 4 5 N/A

If there was a trial, did the special agent assist you in witness preparation and/or conduct follow-up leads developed after the prosecutive report was prepared?

1 2 3 4 5 N/A

If you declined prosecution after the preparation of a prosecutive report, was it due to:

___the quality of the investigation?
___the lack of evidence to substantiate the charge(s)?
___the availability of administrative/other remedies?
___other reasons (please explain on reverse)?
___not applicable

How would you rate the responsiveness and professionalism of the Office of Investigations?

1 2 3 4 5 N/A

Please feel free to provide comments or suggestions on the reverse side of this form.

Completed by:_____Date:_____
Title:_____

Please return form to:
Director, Analysis and Oversight Division (51X)
Department of Veterans Affairs
Office of Inspector General
P.O. Box 50890
Washington, D.C. 20420

OFFICE OF HEALTHCARE INSPECTIONS

Quality Survey

Welcome! Your opinions are important to us; please take a few minutes to let us know what you think. The Inspector General is committed to improving the quality of service provided to veterans and the Department of Veterans Affairs. Your response will help to provide insight into the quality of service provided on this project.

To begin, first type in the 5 digit pin number.

Please respond to each question.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
(1) The objectives of this review were important to your office.	❍	❍	❍	❍	❍	❍
(2) The review results were discussed fully with appropriate management personnel.	❍	❍	❍	❍	❍	❍
(3) Your written response to the draft report was properly considered in finalizing the report.	❍	❍	❍	❍	❍	❍
(4) Members of the review team conducted themselves in a professional manner.	❍	❍	❍	❍	❍	❍
(5) The review helped you improve the performance of your operation.	❍	❍	❍	❍	❍	❍

Comments:

Copies of this report are available to the public. Written requests should be sent to:

Office of the Inspector General (53B)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

The report is also available on our website:

http://www.va.gov/oig.htm

For further information regarding VA OIG, you may call 202 565-8620.

Cover photo of the National World War II Memorial
Washington, DC by
Joseph M. Vallowe, Esq.
VA OIG, Washington, DC

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
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