Major Management Challenges

Each year, VA's Office of Inspector General (OIG) and the General Accounting Office (GAO) separately identify what they consider to be the major performance and accountability challenges facing the Department. This section of the performance report presents each of these challenges and outlines what steps VA has taken to resolve them.

Major Management Challenges Identified by VA's Office of Inspector General

The following is an update prepared by VA's Office of Inspector General (OIG) summarizing the most serious management problems facing VA, and assessing the Department's progress in addressing them. Although VA does not have specific quantifiable goals and performance measures in place to help resolve these issues, the Department does have corrective action plans in various stages of implementation. Progress will be monitored until each management challenge has been successfully addressed. Department officials have stated their agreement with the conditions the OIG reported. (On these pages, the words "we" and "our" refers to the OIG.)

1. Health Care Quality Management and Patient Safety

Of the many challenges facing VA, one of the most serious, and potentially volatile, is the need to maintain a highly effective health care quality management program. The issues that punctuate the importance of this challenge are VA's need to ensure the high quality of veterans' health care and patient safety, and to demonstrate to Department overseers that VA health care programs are effective.

One example of a particularly difficult and complex undertaking is the need to provide safe, high-quality, patient care in an environment that is rapidly evolving from the traditional specialty-based inpatient care to an ambulatory care/outpatient primary care setting. Increasing reliance on treatment in ambulatory care settings can increase opportunities for clinicians to make errors in treating patients and increase the risk of patients receiving uncoordinated care among various outpatient disciplines. While patients are less vulnerable to hospital-acquired pathogens when they receive care in the ambulatory setting, they are increasingly vulnerable to incurring other medical treatment errors and threats to their safety such as missed diagnoses, inappropriate treatments, prescription errors, and failure to follow up. The health care industry, including the Veterans Health Administration (VHA), needs to identify and correct these kinds of system problems.

A fully functional quality management program should be able to monitor patients' care to ensure their safety and to safeguard, to the extent possible, against the occurrence of inadvertent adverse events, undetected misdiagnoses, failure to treat through uncoordinated care, etc. These types of risk management functions are intended to assure patients that they will be cared for in a manner that promotes their maximum safety while providing them with optimal medical treatment.

In recent years, VHA has not provided consistent clinical quality management leadership at all levels of the organization. This is due in part to the devolution of management authority from VHA Central Office to the Veterans Integrated Service Network (VISN) and individual VA medical center (VAMC) levels, coupled with resource reductions associated with the Veterans Equitable Resource

Allocation model. In 2000, following an OIG review, VHA managers agreed to develop functional descriptions, which would help ensure the consistency of staffing patterns in VAMCs' quality management departments throughout the country. While no two VAMC quality management departments may focus on similar clinical quality issues in the same way, the VHA quality management system may begin to operate in a more consistent manner if the functional guidelines are followed. However, functional and resource disparities continue to impede the Department's ability to identify or measure the extent of possibly widespread unsatisfactory clinical practices, and to devise procedures to correct or eliminate such problems.

VHA's National Center for Patient Safety (NCPS) training on the principles of root-cause analysis, which responded to past OIG recommendations, continues and is well received by VHA employees. NCPS's focus on patient safety and resolving long-standing patient vulnerabilities has helped make VHA medical facilities a safer environment for their patients.

Current Status: Although VHA managers are vigorously addressing the Department's risk management and patient safety procedures in an effort to strengthen patients' confidence while they are under VA care, system issues remain. In addition, concerns exist for the care VA provides veterans in the private sector, e.g., on a contract or fee basis. Patient safety in these settings needs additional quality management attention. For example, patients, their family members, and members of Congress are concerned about patient safety and the quality of care provided in VA contract nursing homes. During our Combined Assessment Program (CAP) reviews[1] , we found that VA contract nursing home inspections were not sufficient to ensure that patient safety and quality of care were equal to that provided in VA nursing homes. Also, in January 1994, the OIG issued a report titled *VHA Activities for Assuring Quality Care for Veterans in Community Nursing Homes* (Report No. 4R3-A28-016) that recommended VHA develop standardized community nursing home inspection procedures and criteria for approving homes for participation in the program. VHA has not implemented the OIG recommendations made in the 1994 OIG report. In addition, the U.S. General Accounting Office (GAO) issued a report in July 2001 that had similar recommendations. We are reviewing the need for additional OIG oversight of VHA's inspections and patient safety measures for veterans' care in contract nursing homes.

VHA is also responsible for overseeing and evaluating care provided to veterans in state veterans homes. In January 1999, the OIG issued a report titled *Evaluation of VHA's State Veterans Home Inspection Process* (Report No. 9HI-A06-014) that indicated state veterans home inspections frequently did not adhere to VHA guidelines because employees did not understand their responsibilities. VHA has not implemented the OIG recommendation that it expeditiously conclude its revision and update of the state veterans home policies and procedures included in the annual inspection guidance issued to VAMCs.

The OIG conducted a nationwide assessment of VHA's policies and practices for evaluating and managing violent and potentially violent psychiatric patients. Our March 1996 report titled *Evaluation of VHA's Policies and Practices for Managing Violent and Potentially Violent Psychiatric Patients* (Report No. 6HI-A28-038) recommended that VHA managers explore network flagging systems that would ensure employees at all VAMCs are alerted when patients who have a history of violence

[1] Through this program, auditors, investigators, and health care inspectors collaborate to assess key operations and programs at VA health care systems and VA regional offices on a cyclical basis.

arrive at a medical center for treatment. VHA concurred that VISN-level/national databases are needed to support information sharing; however, this recommendation has not been implemented.

Another key patient safety and quality management concern is that the credentials and background assessment system for all patient care providers VA uses, whether VA-paid or not, is not consistent. This places veterans at risk if they receive care from a VA contract or part-time provider on a fee basis who may have an adverse clinical practice history unknown to VA or the patient. The OIG remains committed to reviewing the issue of credentials of non-VA providers who treat veterans.

The OIG is focusing on other areas of patient care that are vulnerable to system problems. Specifically, in addition to focusing on patient care and safety issues in VHA contract nursing homes, we are focusing on pain management, clinic waiting times, homemaker/home health services, primary care for patients in the area of mental health, VAMC sanitation and cleanliness, and patient satisfaction as part of our CAP reviews. We are also reviewing quality and access-to-care issues in VHA's community-based outpatient clinics.

VA's Program Response

VHA continues to make significant, nationally recognized progress in its national patient safety/ risk management initiatives. Concerns still exist in oversight of care provided to veterans in contract nursing homes. VHA is currently making final revisions on a comprehensive draft directive, Community Nursing Home Evaluation and Monitoring. Plans are also underway to establish annual review protocols and follow-up training for VA staff who conduct nursing home inspections. Progress is also being made to revitalizing the information system that monitors facility compliance with the annual review of community nursing homes. A new report is designed to monitor compliance with the monthly visit standard.

VHA continues to finalize actions to address the one remaining OIG recommendation on the state veterans home inspection process, involving revision and update of the policies and procedures included in the annual inspection guidance issued to VA medical centers of jurisdiction. Completion of this task involves multiple associated steps. Guidelines for state nursing home care standards have been drafted into a training document. They are being used to "test" the guideline. The directive for the State Nursing Home Care Program will be based on the final state nursing home care regulation and will have to be reviewed and approved by General Counsel. The final directive for every level of care will be held until all regulations (State Nursing Home Care, State Adult Day Health Care, State Home Domiciliary Care, State Home Hospital Care) are final. Recommendation will be implemented in FY 2002.

VHA continues to finalize a computerized advisory directive to reflect the approach that is being taken to initiate a computerized system of flagging repetitively dangerous patients. An initial directive has been reviewed by the General Counsel, and Mental Health program officials and the Office of Information continue with project design. The final product may be available for implementation in January 2004.

VA's system for credentialing health care providers, VetPro, is fully operational, secure and state-of-the-art. VA's Under Secretary for Health recently received the highest Public Health Service's award, the Surgeon General's Medallion, for his leadership in implementing this system. VetPro is an electronic data bank that ensures health care professionals have appropriate degrees and licenses. Streamlining of the system will continue.

2. Resource Allocation

In 1997, Congress required VA to address resource inequities nationwide. Public Law 104-204 mandated that VA develop a plan to improve distribution of resources and ensure veterans equitable access to care across the United States. As a result, VA now uses the Veterans' Equitable Resource Allocation (VERA) system.

Prior to FY 1997, VA used three different resource allocation systems.[2] They were designed to improve certain functions of each preceding funding allocation system. VAMCs received and managed their own budgets, and annual incremental increases were based on prior year allocations. Funds allocated through each of these systems were based on historic funding imbalances which perpetuated inequitable allocations of resources and unequal access to care. The inequities that resulted were caused by a shift in the veteran population demographics without an accompanying shift in resource allocations.

VA developed the current VERA system in response to the legislative mandate and began system implementation in FY 1997. VERA is a capitation-based allocation methodology that moves funds among the VISNs based on patient workload. In FY 2001, $17.7 billion (88 percent of medical care resources) was distributed to VISNs using the VERA system. The system provides some incentives for achieving cost efficiencies and serving more veterans. VISNs maintain responsibility for allocating resources among the facilities in their prescribed geographic areas.

In 1986, Congress requested that VA develop the Decision Support System (DSS), an automated information system. The purpose of DSS was to provide accurate tracking of resource expenditures on a near real-time basis, allowing managers to make more informed and more proactive decisions. Despite the great potential of DSS, VHA has encountered problems implementing and using it in decision-making.

The OIG published a report titled *Audit of Veterans Health Administration Decision Support System Standardization* (Report No. 9R4-A19-075) in March 1999. This report discussed the fact that despite significant expenditures for the development and implementation of DSS, not all VHA facilities implemented and used DSS in the same way. In addition, the report discussed resistance to DSS on the part of many VHA managers. As a result, data were not homogenous across VHA facilities and programs, and DSS could not be used to provide accurate tracking of resource expenditures nor relied upon for decision-making. In March 2001, the OIG closed the DSS report recommendations after VHA published a directive on DSS.

In July 1999, the OIG issued a report titled *Evaluation of VHA Radiology and Nuclear Medicine Activities* (Report No. 9R4-A02-133) that found staffing disparities existed among medical centers with comparable workloads, and most Radiology and Nuclear Medicine Services did not apply staffing guidelines, or there was disparity in the guidelines that were used. We recommended that VHA take action to standardize staffing guidelines for Radiology and Nuclear Medicine Services.

The GAO also issued reports in 1997 and 1998 that found responsibility for generating data and reporting results is fragmented in VA's system. VA managers did not have timely, comparable, and comprehensive information needed to monitor changes in access to care. GAO reported that VA Central Office had not provided criteria or guidance for improving the equity of resource allocations to facilities and that VA did not review Network allocation methods or results to determine whether

2 The other three were: (A) prior to 1985 – Incremental Funding, (B) 1984-1985 – Resource Allocation Model, and (C) 1984-1997 – Resource Planning and Management model.

allocations within each Network were made equitably.

Current Status: The OIG is continuing to assess the Department's allocation of resources. Currently, we are reviewing the management of nurse resources to determine if sufficient staffing resources are allocated and properly distributed to provide optimum patient care.

A review of historical VERA allocation data and results of a recent OIG management review in VISN 8 show that there are problems with the way VERA allocates funds. Over the last 5 years, VERA has resulted in the shifting of significant amounts of resources to VISNs that were previously under-funded. However, resource allocation issues remain unresolved. In August 2001, the OIG issued a report titled *Audit of Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network 8* (Report No. 99-00057-55). The report recommended that the VERA model include Priority group 7 veterans (the majority of whom are currently excluded) so that the total number of veterans enrolled and treated is appropriately considered in funding decisions.

Our CAP reviews from 1999 through 2001 also identified uneven implementation levels and inconsistent utilization of DSS. CAP reviews have identified numerous examples where there was a need to realign staffing and resources to correct identified resource deficiencies. We concluded from CAP reviews that VHA needs to more aggressively assess changing health care system resource needs and direct VISN resources to those facilities experiencing shortages.

In July 2001, DSS program officials provided information that showed DSS was 96 percent standardized. However, VHA officials continue to encounter difficulty convincing some facility and VISN managers to incorporate DSS into their management processes. As a result, DSS is still not a completely effective management tool for monitoring and analyzing resource allocation at any level in VHA. We found that some facilities had completely implemented DSS and used it to a pronounced degree in decision-making. Other facilities ignored DSS, and management at those facilities believed DSS data was unreliable. As a result, resource allocation is considered a significant management challenge in the Department.

VHA has not implemented the OIG recommendation made in the July 1999 report to standardize staffing guidelines for Radiology and Nuclear Medicine Services.

VA's Program Response

VHA has adequately responded to recommendations in the OIG reports on the Decision Support System and the VERA allocation system and no further reporting is required. A final decision has not yet been made about the extent of inclusion of Priority 7 veterans, the lowest priority in the VERA funding distribution. OIG has been provided with a draft of the VHA study on utilization of a variable geographic means test, one option that is being considered. Legislation addressing application of the geographic means test is currently pending. If passed, the legislation will directly impact eligibility status of many veterans, including those now in the Priority 7 category. Such considerations will be inherent in VHA's final determination about the scope of VERA inclusion of Priority 7 veterans.

The proposed directive on Diagnostic Radiology Staffing has been completed, as well as a handbook on Nuclear Medicine and Radiation Safety. Deliberations continue and a final decision on the directive has not yet been made.

3. Compensation and Pension (C&P) Timeliness, Quality, and Inappropriate Benefit Payments

Timeliness and Quality

For the past quarter century, the Veterans Benefits Administration (VBA) has struggled with timeliness of claims processing; it continues to face a large backlog and takes an unacceptably long time to process claims. As of September 30, 2001, VBA reported an inventory of more than 532,000 cases. In FY 2001, VBA reported that C&P rating-related actions took an average of 181 days to process.

In December 1997, the OIG issued a report titled *Summary Report on VA Claims Processing Issues* (Report No. 8D2-B01-001) which identified opportunities for improving the timeliness and quality of claims processing and veterans' overall satisfaction with VA claims services. In our September 1998 report titled *Audit of Data Integrity for Veterans Claims Processing Performance Measures Used for Reports Required by the Government Performance and Results Act* (Report No. 8R5-B01-147) and our October 1998 report titled *Accuracy of Data Used to Measure Claims Processing Timeliness* (Report No. 9R5-B01-005), we reported that three key C&P timeliness measures lacked integrity and that actual timeliness was well above reported timeliness.

Current Status: The Secretary created a new Claims Processing Task Force in May 2001 to propose measures and actions to increase the efficiency and productivity of VBA operations, shrink the backlog of claims, reduce the time it takes to decide a claim, and improve the validity and acceptability of decisions. A report on the Task Force's findings and recommendations was issued. Two major types of claims – claims that are older than 1 year and claims that are caught in the appeals-remand cycle – troubled the Task Force. As a result, the Task Force recommended creating a Tiger Team empowered to cut red tape in order to resolve claims affecting aging veterans. This initiative is expected to make a major impact on the most difficult claims and should reduce the average processing time. Until VA can redesign the appeals and remand process, the Task Force also recommended to the Secretary that each VA regional office (VARO) establish, as a priority, a specialized team to manage and process appeals and remand actions locally.

The Task Force reported the appeals process today is ill suited to serve veterans or VA, and made several recommendations targeted at improving the timeliness of appeals processing. These include: (i) require the Board of Veterans' Appeals to develop and process the current workload of appeals rather than issuing remands, (ii) establish appeals claims processing teams, (iii) improve record recovery from the VA Records Management Center, and (iv) maintain or increase competitive outsourcing of medical examinations. In April 2001, the Secretary also directed the Board of Veterans' Appeals to reduce the time veterans have to wait for appellate decisions. VA needs a better system to manage appeals.

Additional actions taken to improve claims processing timeliness include the development of compensation program outcome statements that reflect the views of key stakeholders. Efforts are currently under way to develop outcome performance measures that support each of the outcome statements. Similar efforts are underway for the pension program. New initiatives for FY 2002 include: development of an on-line application system for C&P benefits; expansion of claims development efforts for service persons awaiting discharge; development of the Personnel Information Exchange System to include all military records centers; implementation of paperless technologies to allow the processing of

claims in a fully electronic environment; centralized C&P training programs; and changes to regulations to permit oral evidence gathering. Actions are also underway to improve the ongoing quality, timeliness, and cost of VHA C&P medical examinations. The OIG plans to continue conducting CAP reviews at VAROs and plans to summarize program findings in FY 2002.

Inappropriate Benefit Payments

VBA needs to develop and implement an effective method of identifying inappropriate benefit payments. Recent OIG audits found that the appropriateness of VBA payments has not been adequately addressed.

Payments to Incarcerated Veterans

In February 1999, the OIG published a report titled *Evaluation of Benefit Payments to Incarcerated Veterans* (Report No. 9R3-B01-031). The review found that VBA officials did not implement a systematic approach to identify incarcerated veterans, and adjust their benefits as required by Public Law 96-385. The evaluation included a review of 527 veterans randomly sampled from the population of veterans incarcerated in 6 states. Results showed that VAROs had not adjusted benefits in over 72 percent of the cases requiring adjustments, resulting in overpayments totaling $2 million. Projecting the sample results nationwide, we estimated that about 13,700 incarcerated veterans had been, or will be, overpaid by about $100 million. Additional overpayments totaling about $70 million will be made over the next 4 years to newly incarcerated veterans and dependents if VBA does not establish a systematic method to identify these incarcerated veterans.

Our July 1986 report titled *Benefit Payments to Incarcerated Veterans* (Report No. 6R3-B01-110) also found that controls were not in place to cut off benefits to veterans when they were incarcerated. That report recommended that a systematic approach be applied; however, actions were not taken to implement the recommendations in the 1986 report.

Current Status: VBA has implemented one of four recommendations from the February 1999 OIG report. The recommendations that VBA: (i) identify and adjust the benefits of incarcerated veterans and dependents, (ii) establish and collect overpayments for released veterans and dependents that did not have their benefits adjusted, and (iii) establish a method to ensure VAROs process identified cases timely, and properly adjust benefits, are unimplemented.

Benefit Overpayments Due to Unreported Beneficiary Income

VBA's Income Verification Match (IVM) did not effectively result in required benefit payment adjustments and identification of program fraud, thus IVM remains a significant internal control and financial risk area. Our November 2000 report titled *Audit of Veterans Benefits Administration's Income Verification Match Results* (Report No. 99-00059-1) found that opportunities exist for VBA to: (i) significantly increase the efficiency, effectiveness, and amount of potential overpayments that are recovered, (ii) better ensure program integrity and identification of program fraud, and (iii) improve delivery of services to beneficiaries.

The audit reported that the potential monetary impact of the OIG findings to the Department was $806 million. Of this amount, we estimated potential overpayments of $773 million associated with benefit claims that contained

fraud indicators such as fictitious Social Security numbers, or some other inaccurate key data elements. The remaining $33 million was related to inappropriate waiver decisions, failure to establish accounts receivable, and other process inefficiencies. We also estimated that $300 million in beneficiary overpayments involving potential fraud had not been referred to the OIG for investigation.

Current Status: VBA has implemented seven of eight recommendations from the November 2000 OIG report. The recommendation to complete necessary data validation of beneficiary identifier information contained in C&P master records to reduce the number of unmatched records with the Social Security Administration remains unimplemented. This recommendation was a repeat recommendation from our 1990 OIG report.

Disability Compensation Benefits for Active Military Reservists

In May 1997, the OIG conducted a review to determine whether VBA procedures ensure that disability compensation benefits paid to active military reservists are offset from training and drill pay as required by law. The OIG report titled *Review of Veterans Benefits Administration's Procedures to Prevent Dual Compensation* (Report No. 7R1-B01-089) identified that VBA had not offset VA disability compensation to 90 percent of the sampled active military reservists receiving military reserve pay. We estimated that dual compensation payments of $21 million were made between FY 1993 and 1995 and, if the condition was not corrected, annual dual compensation payments, estimated at $8 million, would continue to be made. Dual payments occurred because procedures established between VA and the Department of Defense (DoD) were not effective or were not fully implemented.

Current Status: VBA has not implemented the recommendation to follow up on FY 1993-1996 dual compensation cases to ensure either VBA disability payments are offset or DoD is informed of the need to offset reservists' pay.

Benefit Overpayment Risks Due to Internal Control Weaknesses

In FY 1999, the Under Secretary for Benefits asked for OIG assistance to help identify internal control weaknesses that might facilitate or contribute to fraud in VBA's C&P program. The request followed the discovery that three VBA employees had embezzled over $1 million by exploiting internal control weaknesses in the C&P program. Our vulnerability assessment identified 18 categories of vulnerability involving numerous technical, procedural, and policy issues. The Under Secretary for Benefits agreed to initiate actions to address the weaknesses identified.

To test the existence of the control weaknesses identified in the vulnerability assessment, we conducted an audit at the VARO in St. Petersburg, FL. That VARO was selected for review because it was one of the Department's largest VAROs, accounting for 6 percent of C&P workload and was the location where two of three known frauds took place. The July 2000 report titled *Audit of the Compensation and Pension Program's Internal Controls at VA Regional Office St. Petersburg, FL* (Report No. 99-00169-97) confirmed that 16 of 18 categories of vulnerability reported in our vulnerability assessment were present at the VARO.

Current Status: There is an ongoing criminal investigation at the VARO in Atlanta, GA, where an estimated $11 million in fraudulent benefits were processed. At the request of the Secretary, the IG agreed to conduct a review of all onetime C&P payments, valued at $25,000 or more, made since 1995, to determine if the payments were valid. The OIG will also conduct CAP reviews at selected VAROs to assess internal control weaknesses previously identified in our vulnerability assessment along with reviewing other related claims processing issues.

VBA agreed to address the 18 internal control weaknesses identified in the vulnerability assessment and the 15 multi-part recommendations identified in the St. Petersburg audit. Implementation action on these recommendations is currently in progress.

VA's Program Response

Timeliness and Quality

VBA established five teams to address the major recommendations in the report issued by the Claims Processing Task Force. The reports from all the teams have been completed and are being reviewed by senior management. VBA has taken action on many of the recommendations, and the Secretary was briefed in late December 2001.

In addition, a working unit comprised of six VBA employees and five Board of Veterans' Appeals (BVA) employees has been established. The BVA employees are currently receiving training on VBA's evidence-gathering process and systems. Previously, BVA would refer all remand actions to the field stations for completion. The current agreement between VBA and BVA states that BVA employees will now process remand actions instead of referring the requests to the field stations. The six VBA employees will make decisions and generate payments on the appeals.

VBA has begun the process of centralizing work processes. The Tiger Team, located in Cleveland, OH, is fully operational at this time. It has been processing claims for veterans over the age of 70 who have been awaiting a decision for over 1 year.

In addition, three Pension Maintenance Centers have been established and have begun processing Eligibility Verification Reports. They are expected to begin processing matching programs in April 2002. Training is currently underway in all three sites.

Inappropriate Benefit Payments

Payments to Incarcerated Veterans

Federal Prisons

Since April 1998, VA has been receiving files from the Federal Bureau of Prisons (BOP) identifying VA beneficiaries who are incarcerated by BOP. Every month VA receives a file of accessions to the BOP population. That file is matched with the file of C&P master records on Social Security Numbers (SSN). If there is a match, a worksheet and listing are generated to the VA regional office of jurisdiction for appropriate action. The BOP match is working very well with a low percentage of bad hits. However, the match will fail if the BOP has the wrong SSN for the prisoner or if VA has the wrong or no SSN for the VA beneficiary.

State & Local Prisons

VA entered into a Memorandum of Understanding (MOU) with the Social Security Administration (SSA) to get access to SSA's file of individuals

incarcerated by state and local governments. In March 2001, VA received a test file from SSA. Based on the output, it was necessary to refine criteria for the match. VBA has prepared a Project Initiation Request (PIR) to modify the programming necessary to conduct the match. It is anticipated that the match will be run on or about April 30, 2002.

We are unable at this time to estimate when we will release output from the state/local prisoner match to regional offices. We expect that the results of the next test run will be received by May 23, 2002. If the results do not reveal significant problems with the match, VBA will start releasing output to field stations within 60 days of the test.

The establishment and collection of overpayments for released veterans and dependents after the beneficiary was incarcerated by state or local governments who did not have their benefits adjusted were contingent upon VA getting acceptable output from the match with SSA.

Benefit Overpayments Due to Unreported Beneficiary Income

In order to implement the final recommendation, the Social Security Administration (SSA) recommended that VA use the "no surname match" routine in its State Verification and Exchange System (SVES) to more accurately conduct Social Security number verification. Using this routine, SSA will verify a payee's SSN if the SSN and date of birth and first initial of the first name match in VA and SSA records. If these elements do not match, the case will be identified as unverified. The individual's sex and last name will no longer be considered in determining whether there is a match. A PIR to modify the programming is being prepared. The intent of program changes is to get accurate SSNs into the system so we can better match data for the Income Verification Match and all other matches. It is not possible to provide an estimated date of installation until the PIR has been evaluated at the Hines Benefits Delivery Center (BDC), but we expect that it will be operational before the end of FY 2002.

Disability Compensation Benefits for Active Military Reservists

Allegations of problems with drill pay files from DoD date back to 1989 when VA attempted to move from annual waivers to a onetime waiver. After a hiatus of several years when no computer matching agreement was in place to support the match, VA and the Defense Manpower Data Center (DMDC) started matching again in 1999. The BDC sent a file of 2,660,266 active C&P records to DMDC to be matched for reservist drill days. On June 23, 1999, the return file was received from the DMDC with 56,884 matches covering fiscal years 1993-1998.

Because of concerns about the accuracy of DMDC files, VBA decided to test the accuracy of the data by doing a limited mailing to selected test stations. On January 26, 2000, Hines released fiscal year 1999 drill pay cases from four regional offices. A total of 751 waiver forms were released. However, review of copies of the waiver forms uncovered anomalies in the reported training days for reservists. Work to resolve this issue is ongoing, and release of the national review data will be done as soon as a solution is deployed.

VA received a letter dated June 13, 2001, from DMDC in which the Director explained that the Defense Finance and Accounting Service (DFAS) office in Denver discovered an error in its reporting of drill information to the DMDC affecting Army, Navy, and Air Force

pay data. The large majority of reservists served in these branches of the military. DMDC reports that Denver DFAS is unable to provide corrected submissions for drill data prior to April 2001. Hines currently has the FY 2001 drill pay file from DMDC, and it will be run before the end of FY 2002.

4. Government Performance and Results Act (GPRA) - Data Validity

Successful implementation of GPRA, including performance-based budgeting, requires that information be accurate and complete. At the request of the Assistant Secretary for Policy and Planning, we initiated a series of audits to assess the quality of data used to compute the Department's key performance measures. The OIG has completed work on the following six performance measures:[3]

- Average days to complete original disability compensation claims – 34 percent of the records reviewed contained inaccurate or misleading data.
- Average days to complete original disability pension claims – 32 percent of the records reviewed contained inaccurate or misleading data.
- Average days to complete reopened compensation claims – This number of reopened claims was inflated by 18 percent. Of the records reviewed, 53 percent contained inaccurate or misleading data.
- Percent of the veteran population served by the existence of a burial option within a reasonable distance of place of residence – VA could not recreate population projections used to calculate this measurement because essential data no longer existed.
- Foreclosure avoidance through servicing ratio – The OIG was unable to attest to the accuracy of the reported ratio because VBA did not maintain necessary documentation.
- Unique Patients – VHA overstated the number of unique patients by 7 percent.

Deficiencies were identified in each performance measure audited. VBA, VHA, and NCA have taken action to correct the deficiencies and have implemented all the recommendations in the OIG reports related to these deficiencies.

VA has made progress in implementing GPRA, but additional improvement is needed to ensure that stakeholders have useful and accurate performance data. Management officials continue to refine performance measures and procedures for compiling data. Performance data are receiving greater scrutiny within the Department, and procedures are being developed to enhance data validation. However, we continue to find significant problems with data input, and departmentwide weaknesses in information system security limit our confidence in the quality of data output.

Current Status: The Office of the Assistant Secretary for Management has identified the following management challenges to the successful implementation of GPRA.

- Better alignment of budget accounts with GPRA programs.
- Improvement of financial management systems report structure and timeliness.
- Improvement of cross-cutting activities between VA and DoD.

Audits of three key performance measures – the VHA prevention index, the VHA chronic disease

[3] The three claims processing timeliness measures we audited have now been incorporated into a new key measure called average days to process rating-related actions.

care index, and the accuracy of the VBA veteran rehabilitation rate – are in process.

5. Security of Systems and Data

VA faces significant challenges in addressing federal information security program requirements and establishing a comprehensive integrated VA security program while homeland security risks continue to escalate. Information security is critical to ensure the confidentially, integrity, and availability of VA data and the assets required to support the delivery of health care and benefits to the Nation's veterans. VA provides medical services at over 1,150 sites, a benefits delivery network of 57 VAROs, a burial system involving 119 national cemeteries, maintains 3 major data processing centers, and provides other Departmental functions. VA is highly dependent on automated information systems to support its mission to deliver services to our Nation's veterans.

The three VA administrations' stovepipe operations have not adopted standard hardware and software integration, which contributes to security vulnerabilities in the Department. Decentralization of information technology and lack of management oversight at all levels have also contributed to inefficient practices and to weaknesses in safeguarding electronic information and physical security of assets.

Previous OIG audit reports have identified weaknesses in information security throughout VA. With passage of the Government Information Security Reform Act (GISRA) as part of the FY 2000 Defense Authorization bill, the OIG is required to complete an independent assessment of VA's compliance with the Act. Limited information had been developed by VA on existing information security vulnerabilities that could be analyzed to establish a baseline on the adequacy of VA's information security. Therefore, the OIG performed vulnerability assessments and penetration tests of selected segments of the Department's electronic network of operations to identify vulnerabilities that place sensitive data at risk of unauthorized disclosure and use.

Current Status: Our October 2001 report, titled *Audit of the Department of Veterans Affairs Information Security Program* (Report No. 00-02797-001), found that weaknesses exist and, as a result, require the continuing designation of information security as a Department material weakness area under the Federal Managers' Financial Integrity Act. VA systems continue to be vulnerable to unauthorized access and misuse of sensitive automated information and data. The Department has started efforts to correct these weaknesses and work toward compliance with the GISRA requirements; however, results of the recently completed GISRA audit identified significant information security vulnerabilities that continue to place the Department at risk of:

- Denial of service attacks on mission-critical systems.
- Disruption of mission-critical systems.
- Unauthorized access to and disclosure of data subject to Privacy Act protection and sensitive financial data.

In addition, the following key issues were identified:

- VA has established comprehensive information security policies, procedures, and guidelines, but implementation and compliance have been inconsistent.
- VA has been slow to implement a risk management framework. As a result, VA does not comply with GISRA; Office of Management

and Budget (OMB) Circular A- 130, Appendix III; and Presidential Decision Directive 63 security requirements.

- Penetration tests verified that VA systems could be exploited to gain access to sensitive veteran benefit and health care information.

Results of our September 30, 2000 consolidated financial statements audit have also continued to identify information security weakness. This report titled *Audit of the Department of Veterans Affairs Consolidated Financial Statements For Fiscal Years 2000 and 1999* (Report No. 00-01702-50) found management oversight and control weaknesses continue to be problems in the security of sensitive information. The newly confirmed Chief Information Officer/Assistant Secretary for Information and Technology has taken an aggressive approach to correcting identified weaknesses and hardening the security of the Department's electronic information.

VA's Program Response

The OIG, the General Accounting Office, and VA security staff members have, for the past several years, reported on core deficiencies existing in the Department's segmented information security programs. Although some identified weaknesses were the result of insufficient funding being available to upgrade IT assets to more secure hardware and software configurations, most deficiencies were attributed to the lack of centralized security management, oversight, and control. During the past year, a number of aggressive actions have been initiated to develop a comprehensive, departmentwide security program targeted toward enhancing VA's overall IT security posture, including ensuring compliance with related OMB and Congressional directives.

This year, the Secretary realigned departmentwide IT security responsibilities under a single focal point. The Chief Information Officer (CIO) has been vested with authority to provide guidance and direction for all IT technical and security issues. The CIO manages the Department's security program through the newly established Office of Cyber Security (OCS). The office is serving as the focal point for leveraging existing resources and implementing security initiatives on a global basis within the Department.

During the past year, IT security has received priority attention at all Department levels. The focus on security has been revitalized in VA's Information Technology Board through establishment of a Cyber Security Subcommittee to identify areas of concern, coordinate policy issues, and share concepts for related best practices. Successes in FY 2001 include:

- Remote penetration testing has been conducted to support the Department's commitment to conduct active compliance monitoring and identification of continuing security weaknesses.

- Intrusion detection systems have been fielded at a number of locations within the Veterans Health Administration and the Veterans Benefits Administration as a precursor to implementing global intrusion detection capability.

- The VA Computer Incident Response Capability has been expanded to operate on a 24/7 basis to coordinate data on threat and vulnerability issues, cyber security incidents, and appropriate countermeasures.

- A departmentwide anti-virus regime is currently being deployed to better prevent and contain virus outbreaks that continue to occur

in VA, disrupt services and divert the efforts of technical staff.

In addition to these initiatives, the CIO initiated the first-ever departmentwide cyber security program review. This review coincided with VA's implementation of provisions of the Government Information Systems Reform Act (GISRA). During the review, a self-assessment survey containing 247 security-related elements was completed by respective IT and security staffs providing logistical support for each of VA's 995 systems and major applications.

As expected, the results of the GISRA self-assessment survey confirmed the lack of security management for IT assets. Overall, less than 70 percent of VA systems and major applications had effectively implemented IT security controls in such areas as segregation of duties, access controls, and entity-wide security program planning and management. Even for those systems reporting that controls were in place, there was almost no independent validation to ensure compliance with previously established security procedures. Correspondingly, many of the deficiencies identified in the surveys were cited in prior audits, and had not been adequately remedied. Although this process identified deficiencies in great detail, it was used as an effective management tool to identify and address the underlying lack of line management accountability, a contributing factor to VA's current security weaknesses.

Upon receipt of the Department's first GISRA Report, OMB commented in a November 16, 2001, memorandum to the Secretary, "On IT security, the CIO's security report is clear, coherent and shows that a comprehensive Department-level security program is developed and has begun. It is not clear how the Department-level program will be implemented at lower level. Specifically, it does not describe how the approach will correct the security issues that have long plagued the operating administrations, i.e., the Veterans Health Administration and the Veterans Benefits Administration."

The momentum for change established this year will be carried forward. The CIO's near-term focus is to build upon current initiatives including:

- Preliminary intrusion detection projects will be expanded to a departmentwide capability.
- Capabilities for compliance support and independent validation for GISRA remediation efforts will be established.
- Comprehensive policies for authentication, certification, and accreditation will be developed and implemented.

The success of current initiatives, future initiatives, and the extensive direction and support provided by the Secretary, the VA CIO, and Administration CIOs, reaffirm that this program is one of VA's highest priorities.

6. Federal Financial Management Improvement Act (FFMIA) and VA's Consolidated Financial Statements (CFS)

The Chief Financial Officers Act of 1990, Government Management Reform Act (GMRA) of 1994, and implementing OMB Bulletins require that VA's consolidated financial statements (CFS) be audited annually by the OIG or the OIG's representative. The agency CFS and related audit reports are integral to the Governmentwide CFS prepared by the Department of the Treasury and audited by the GAO. VA's FY 2000 CFS reported assets totaling $44 billion, liabilities totaling $583 billion, and net operating costs of $45 billion.

VA achieved unqualified CFS audit opinions in FY 2000 and FY 1999. VA has also demonstrated

management commitment to addressing material internal control weaknesses previously reported and made significant improvements in financial management. However, remaining material weaknesses are still considered significant, such as noncompliance with the Federal financial management system requirements of the Federal Financial Management Improvement Act (FFMIA). Corrective actions needed to address noncompliance with system requirements are expected to take several years to complete. The OIG also reported other significant conditions addressing the need for improving application programming and operating system change controls, business continuity and disaster recovery planning, and operational oversight.

Current Status

Integrated Financial Management System Material Weakness

The material weakness concerning the Department's financial management systems underscores the importance that the Department continue its efforts to acquire and implement a replacement integrated core financial management system. However, achieving the success of an unqualified opinion currently requires a number of manual compilations and extraneous processes that the financial management system should perform. These processes require extraordinary administrative efforts by Department program, financial management, and audit staff. As a result, the risk of materially misstating financial information is high, considering the need to perform extensive manual compilations and extraneous processes. Efforts are still needed to ensure adequate accountability, and reliable, useful, and timely information needs to be available to help Department officials make well-informed decisions and judgments.

The February 2001 OIG CFS report noted continuing difficulties related to the preparation, processing, and analysis of financial information to support the efficient and effective preparation of VA's CFS. Examples cited by the CFS auditors include:

- General ledgers for some smaller funds are maintained outside the existing core financial management system.
- Unreconciled differences between the general ledgers and the Property Management System subsidiary ledger exist.
- A significant number of manual adjustments were used during the year-end closing process.

Information Technology Security Controls Material Weakness

The OIG reported this condition in the CFS reports for FY 1997, 1998, and 1999 and made recommendations for VA to implement a comprehensive security program that would improve these controls. The CFS auditors noted the following information technology weaknesses:

- Inadequate security plans and security administration.
- Improper access by programming staff.
- Inappropriate access capabilities by application programmers.
- Inadequate review, investigation, and documentation of network access exceptions.
- Physical access to computer rooms storing production hardware by individuals with incompatible duties.

- Inconsistent anti-virus software upgrades at all locations and improper setup to alert administrators to take prompt actions.

The size of VA programs and the large number of systems that generate program and financial information make correction of existing material weaknesses very complex. VA is also dependent on the receipt of funding through OMB and Congress to implement corrective actions. The target date for completing corrective actions on the information technology security control weaknesses is FY 2003, and corrective action on financial management system deficiencies is FY 2004, when implementation of VA's core Financial and Logistics System (coreFLS) project is scheduled for completion.

VA's Program Response

During the past year, the Department has directed priority attention to remediating material weaknesses in IT security controls reported under the Federal Financial Management Improvement Act (FFMIA). In August 2001, the Chief Information Officer (CIO) initiated the first-ever departmentwide cyber security program review. This review coincided with VA's implementation of the Government Information Systems Reform Act (GISRA). A GISRA self-assessment survey containing 247 security-related elements was completed by respective security and IT staffs providing logistical support for each of VA's 995 systems and major applications.

The results of the GISRA surveys were analyzed under the six specific control categories identified in the General Accounting Office's Federal Information System Controls Audit Manual (FISCAM). The use of these FISCAM categories was deemed particularly appropriate, since FISCAM provides guidance for reviewing information system controls that affect the integrity, confidentiality, and availability of data. These are the specific areas that require significant improvement in order to remediate the FFMIA material weakness.

7. Debt Management

As of March 2001, debts owed to VA totaled over $4 billion. Debts result from home loan guaranties, direct home loans, life insurance loans, medical care cost fund receivables, compensation, pension, and educational benefits overpayments. Over the last 4 years, the OIG has issued reports addressing the Department's debt management activities. We reported that the Department should be more aggressive in collecting debts, improve debt avoidance practices, and streamline and enhance credit management and debt establishment procedures. VA has addressed many of the concerns reported over the last few years. However, our most recent national and CFS audits and CAP reviews continue to identify debt management issues.

There has been a great deal of dialog and sharing of information between the OIG and VA management to assess the current magnitude of the debt management issues. For example, VBA direct home loans is considered a lender of last resort. Consequently, if a borrower defaults on a loan, few resources are available for VA to collect. However, we feel there are other debt management issues that VA can improve. Issues identified by the OIG relate to: accounts receivable follow-up, timely reconciliation, and billing process problems.

In March 1999, we conducted an evaluation of VHA's Income Verification Match (IVM) program to: (i) follow up on the implementation of recommendations made in a March 1996 OIG report, and (ii) determine whether there were opportunities for VHA to conduct the IVM program in a more efficient and cost effective manner. The OIG report titled *Evaluation of VHA's Income*

Verification Match Program (Report No. 9R1-G01-054) found that VHA could increase opportunities to enhance Medical Care Cost Fund (MCCF) collections by $14 million, and put resources valued at $4 million to better use, by requiring VISN directors to establish performance monitors for means testing activities, and billing and collection of program referrals. Additionally, to further ensure these monetary benefits are achieved, VHA management needed to implement previous recommendations, and the VHA Chief Information Officer needed to increase oversight of the Health Eligibility Center (HEC) activities. VHA also needed to expedite action to centralize means testing activities at the HEC.

Current Status: The Department has performed considerable work in the area of the debt referral process with the Department of the Treasury. VA has reported it has met or exceeded Department of the Treasury goals this year – demonstrating a commitment to improving debt management within the Department.

VHA has not implemented 7 of 13 recommendations from the March 1999 OIG report on VHA's IVM program.

The OIG is currently conducting an audit to determine VHA's success with MCCF and to identify opportunities to enhance MCCF recoveries. Preliminary audit results show that previously reported conditions, including missed billing opportunities, billing backlogs, and minimal follow-up on accounts receivable, are still continuing. Also, insurance identification procedures need improvement. Our July 1998 audit found MCCF recoveries could be increased significantly by more actively managing MCCF program activities; however, our follow-up indicates the recommendations were not effectively implemented.

VA's Program Response

VHA continues to implement the outstanding recommendations for the report on the Income Verification Match (IVM) program. The Health Eligibility Center (HEC) has established mechanisms to ensure that IVM conversion cases are referred to all sites of care for appropriate billing action. HEC is working with the VISNs to establish performance standards that require staff involved in the means test co-payment billing process to administer IVM referral cases in a timely manner. HEC also has reporting capabilities that will enable staff at the medical facilities and Networks to monitor and track billing and collection activities. A directive is being prepared for distribution to the Networks and facilities that describes the restart of the IVM process, the new reporting procedures, and draft performance standards for field staff involved in revenue activities related to IVM means test co-payment billing. The target date to resume income verification is April 2002. Redesign of the HEC database and implementation of a national Centralized Renewal of Means Test continue to be on an expedited schedule and are on target for completion by October 2002.

In terms of MCCF activities, VHA's revenue office continues to spend considerable time and effort in identifying opportunities to improve the revenue process. The Revenue Improvement Plan (addressing MCCF issues), completed in September 2001, is a comprehensive document that addresses all aspects of the revenue cycle. It includes an overall improvement plan, responsibilities and time frames for completion. All of the recommendations identified by OIG are addressed in the plan, as are recommendations that were made by reviews conducted by the Financial and Systems Quality Assurance Service (FSQAS).

8. Workers' Compensation Costs

The Federal Employees' Compensation Act (FECA) authorizes benefit payments to civilian employees of the Federal Government for disabilities or deaths resulting from injuries or disease sustained in the performance of their official duties. The benefit payments have two components – salary compensation payments and medical treatment payments for specific disabilities. Benefit payments under FECA are made from the Employees' Compensation Fund administered by the Department of Labor, Office of Workers' Compensation Program (OWCP).

During the period July 1998 through June 1999, VA's OWCP costs totaled over $137 million for the 15,287 active cases. Wage loss compensation was over $106 million (77 percent) and medical costs were over $31 million (23 percent). VHA accounts for about 95 percent of VA's total OWCP cases and costs.

In 1999, we completed a follow-on audit of high-risk areas in VHA's Workers' Compensation Program (WCP). The audit found that VHA was vulnerable to abuse, fraud, and unnecessary costs associated with WCP claims in three high-risk areas reviewed: dual benefits, non-VHA employees, and deceased WCP claimants. We estimated that VHA has incurred or will incur about $11 million in unnecessary costs associated with WCP claims in these high-risk areas.

Current Status: The OIG continues to provide technical support and assistance to the Department in its efforts to reduce WCP costs and identify WCP fraud. The OIG identified 82 claims during its FY 1999 audit titled *Audit of High-Risk Areas in the Veterans Health Administration's Workers Compensation Program* (Report No. 99-00046-16) that involved potential WCP fraud. Efforts to continue identifying potential program fraud were addressed when the OIG provided two training sessions prior to VHA's one-time review of priority cases identified by automated analysis of VHA's active/open WCP cases. While VHA's reviews did identify cases they believed to be potential fraud, no investigations have been opened on these cases because additional documentation and evidence were needed. The OIG staff discussed these cases with VHA staff. VHA is working to provide documentation to the OIG.

Additionally, a VA OIG WCP resources Web page (www.va.gov/oig/52/wcp/wcp.htm) was created to allow VA employees to easily find and download WCP products. This Web page contains presentations, reports, and other WCP products, such as the fraud awareness bulletin. It also contains links to VA OIG Office of Investigation press releases on WCP cases.

VA's Program Response

VHA participates actively in the WCP fraud prevention program, and routinely reports cases of potential abuse. Approximately 40-50 cases have already been referred, although it is recognized that not all have met OIG's criteria for actual fraud.

9. Procurement Practices

The Department spends over $5.1 billion annually for supplies, services, construction, and equipment. VA faces major challenges to implement a more efficient, effective, and coordinated effort that can better ensure the Department's acquisition and delivery efforts to acquire goods and services. A more integrated effort is needed to ensure the benefits of acquiring goods and services outweigh costs. High-level monitoring and oversight need to be recognized as a Department priority, and efforts must continue to maximize the benefits of competition and leverage VA's full buying power. VA must also ensure that adequate levels of medical

supplies, equipment, pharmaceuticals, and other supplies are available to satisfy demand. Excess inventory should be avoided so funds that could be used to meet other needs are not tied up.

Historically, procurement actions are at high risk for fraud, waste, abuse, and mismanagement. Vulnerabilities and business losses associated with theft, waste, and damage of information technology are known to be significant. Past audits support the need to provide for adequate acquisition planning on a corporate basis, and to improve and coordinate national and regional acquisition planning efforts.

Current Status: Recent OIG reviews have identified serious problems with the Department's contracting practices and acquisitions. These reviews have identified the need to improve the Department's procurement practices in areas of acquisition training and oversight, and to better ensure the adequacy and competency of the acquisition workforce. Recent business reviews conducted by VA's Office of Acquisition and Materiel Management (OA&MM), and other audits conducted by the OIG at VA facilities, have identified significant problems relating to acquisition planning, training, inventory management, management oversight, and contract administration.

The OIG is working with VA and VHA logistics staff to improve procurement practices within the Department. The OIG continues to perform contract audit and drug pricing reviews to detect defective and excessive pricing, and to provide improved assurance over the justification, prioritization, accountability, and delivery of pharmaceuticals and other goods in VA's operations. VHA has made the development of an Advanced Acquisition Plan a priority.

An OA&MM Task Group was charged with developing an inventory of procurement problems in December 2000. The Group identified problems with noncompliance with acquisition regulations and poor contract administration on individual procurements as being caused by the failure to hire competent procurement officials, inadequate training, undue pressure, and weak or inconsistent procurement policies. Inadequate or non-existent acquisition planning at the local, VISN, and national levels was also identified. The Group provided a number of recommendations to address these problems effectively and recommended actions that should improve planning, coordination, and accountability at all Department levels.

Also, the OA&MM Group identified continuing problems with inventory management, purchase cards, scarce medical specialist/sharing contracts and information technology purchases as areas needing immediate review. The group suggested that subgroups consisting of representatives of VHA, OA&MM, OIG and other appropriate offices be formed to address these issues. Subgroups are currently working on addressing specific issues.

Federal Supply Schedule Purchases

Federal Supply Schedule (FSS) contracts are awarded non-competitively by the National Acquisition Center to multiple vendors for like or similar commercial off-the-shelf products. The Government's negotiation strategy has historically been to obtain most-favored customer pricing or better. Since 1993, the OIG has conducted pre-award and post-award reviews to provide contracting officials with insight into each vendor's commercial sales and marketing practices as well as buying practices. These reviews provide contracting officers with information needed to strengthen the Government's pricing position during negotiations. During the past few years, the effectiveness and integrity of the FSS program have deteriorated because FSS is no longer a mandatory source for these commercial products.

As a result of making FSS contracts non-mandatory sources of supply, there has been an increase in open-market purchases by VAMCs, often without attempts by them to either negotiate prices or determine price reasonableness. The term open-market describes the purchase of goods and services that are not on contract. In increasing numbers, vendors have: (i) withdrawn high-volume medical supply items from FSS contracts, (ii) refused to negotiate in good faith, (iii) cancelled contracts, or (iv) not submitted proposals for FSS contracts.

Although these vendors no longer have contracts, they have not lost their VA market share. They continue to sell in large volumes to individual VAMCs and avoid offering most favored customer prices, shielding themselves from pre-and post-award reviews. In addition, they are able to sell products made in non-designated countries directly to VA facilities that they cannot sell on FSS or other contracts because of the Buy America and Trade Agreements Act requirements. Previous OIG investigations have resulted in $8 million in civil penalties being imposed on violators of the Act.

Current Status: The OIG CAP reviews at VAMCs have identified non-competitive open-market purchases at significantly higher prices than comparable items offered on FSS contracts. Our reviews have also identified conflict of interest issues and proposed sole source contracts that lack adequate business analyses, justifications, or cost/benefit assessments. Many proposals are not being audited as required and may not be receiving legal and technical reviews as required. Management attention is needed to develop clear and useful policies that will ensure fair and reasonable prices, consistency in the use of VA's statutory authority, and proper oversight of such activities.

Inventory Management

The OIG conducted a series of four audits to assess inventory management practices for various categories of supplies. These audits found that excessive inventories were being maintained, unnecessary large quantity purchases are occurring, inventory security and storage deficiencies exist, and controls and accountability over inventories need improvement. An FY 1998 audit of medical supply inventories at five VAMCs found that at any given time, the value of VHA-wide excess medical supply inventory was $64 million, 62 percent of the $104 million total inventory. An FY 1999 audit of pharmaceutical inventories at four VAMCs found that about 48 percent of the $2 million inventory was in excess of current operating needs. Another audit in FY 2000 at five VAMCs concluded that 47 percent of the $3 million prosthetic supply inventory was excessive.

The main cause of the excess inventories was that the Generic Inventory Package was not being used or was insufficiently used to manage the inventories. VAMCs relied on informal inventory methods and cushions of excess stock as a substitute for the more structured Generic Inventory Package inventory management system. The successful transition to prime vendor distribution programs for pharmaceuticals and other supplies has helped reduce pharmacy inventories from previous levels. However, inventories continue to exceed current operating needs for pharmaceuticals and many other items.

Current Status: The last of the four OIG audits completed in FY 2001 concluded that 67 percent of the $5 million engineering supply inventory used for maintaining and repairing buildings, equipment, furnishings, utility systems, and grounds at five VAMCs was excessive. At any given time, the estimated value of the four types of inventories was about $435 million.

CAP reviews continue to identify numerous inventory management problems. In addition, problems associated with prime vendor programs have identified areas where supplies are being

acquired at increased costs and/or waste has occurred.

Government Purchase Card Use

OIG audits and reviews at selected VAMCs have identified significant vulnerabilities in the use of Government purchase cards. Purchases have been split to circumvent competition requirements and some goods and services have been acquired at excessive prices and without regard to actual needs. Our reviews of purchase card records, invoices, purchase orders, procurement history files and other related records, also lead us to believe that VHA is purchasing open-market health care items in amounts greater than the 20 percent maximum allowed under Title 38 U.S.C. §8125(b)(3)(A).

Current Status: Of 33 CAP reports issued from March 31, 1999 to April 11, 2001, 22 identified Government purchase card problems such as the lack of timely reconciliations and certifications, inappropriate approving officials, improper purchases, exceeded purchasing limits, and poor internal controls. These conditions are a result of the widespread and essentially unmonitored use of Government purchase cards in conjunction with the decentralization of purchasing authority to VAMCs. If uncontrolled, risk will escalate as purchase card use increases throughout the Department.

Scarce Medical Specialist Contracts

OIG reviews of scarce medical specialist contracts have identified serious concerns about whether contracts are necessary and costs are fair and reasonable. Reviews have also identified conflict of interest issues and proposed sole source contracts that lack adequate business analyses, justifications, or cost/benefit assessments. Most importantly, the requirement that noncompetitive contracts must be based on cost or pricing data was not enforced. Consequently, VAMCs paid excessive charges on certain contracts. VHA issued guidance and provided training that significantly improved contracting practices. However, we have found that VAMCs have been inappropriately using Intergovernmental Personnel Act assignments and commercial items contracts as a substitute for scarce medical specialist contracts. Use of these purchasing methods, in lieu of contracts, has resulted in higher prices being paid for services than would have been paid using properly negotiated contracts. Management needs to improve oversight to ensure that, when applicable, properly negotiated contracts are used. Furthermore, management needs to develop and/or enforce policies that ensure consistent compliance with VA's statutory authority in order to obtain reasonable prices.

Current Status: During FY 2001, we completed contract reviews of seven health care resource contract proposals involving scarce medical specialists' services. We concluded that the contracting officer should negotiate reductions of over $2 million to the proposed contract costs.

Controls Over the Fee-Basis Program

We conducted an audit to determine if VHA had established effective internal controls to ensure that payments for fee-basis treatment were appropriate. Fee-basis treatment is inpatient care, outpatient care, or home health care received from non-VA health care providers at VA expense. In June 1997, the OIG issued a report titled *Audit of Internal Controls over the Fee-Basis Program* (Report No. 7R3-A05-099) that found VHA could reduce fee-basis home health care expenditures by at least $1.8 million annually and improve the cost effectiveness of home health services by: (i) establishing guidelines for contracting for such services, and (ii) providing contracting officers with benchmark rates for determining the reasonableness of charges.

Current Status: VHA has not implemented the OIG recommendations in the June 1997 report to establish guidelines for contracting and provide contracting officers with benchmark rates.

VA's Program Response

In November 2000, at the request of the Deputy Under Secretary for Health and the Principal Deputy Assistant Secretary for Management, an Acquisition Issues Task Group prepared a detailed analysis of procurement problems in VHA. The IG served as a member of this group. Some recommendations of this group have been completed or partially completed. Others have been put on hold pending the outcome of the Secretary's Procurement Reform Task Force. This work group was formed in July 2001 and was tasked to look into similar procurement issues.

Inventory Management

Inventory management problems noted in two OIG reports are addressed in VHA Handbook 1761.2, issued in October 2000. Implementation of the handbook has been delayed because the National Labor Management Organizations (AFGE and NAGE) have requested a national demand to bargain. In August 2001, VA Central Office signed an understanding with AFGE, effectively allowing all AFGE facilities to proceed with implementation of the handbook. However, discussions are still being conducted with NAGE. An Information Letter (IL) 17-01-01 to address one recommendation in OIG report, *Audit of VAMC Management of Engineering Supply Inventories* (Report No. 99-00192-65), and an amendment to VHA Handbook 1761.2 to address four recommendations in OIG report, *Audit of VAMC Management of Pharmaceutical Inventories* (Report 99-00186-86), are currently in concurrence.

Government Purchase Card Use

The Office of the Chief Financial Officer is finalizing corrective actions pertaining to VHA on the one remaining OIG recommendation "Strengthen controls over the Purchase Card Program by establishing appropriate mechanisms to monitor unreconciled transactions on a VA-wide basis" that is found in OIG report *Audit of VA's Purchase Card Program (*Report No. 9R3-E99-037). VHA requirements have been provided to the coreFLS analysts at the contractor, KPMG Consulting, to ensure the new system can provide the reports. It is expected that all required reports will be available by the time the Department begins the nationwide implementation scheduled for April 2003. OIG will close the recommendation when further validation of these actions is received from the contractor. This response is currently being solicited by VHA.

Scarce Medical Specialist Contracts

Many of the problems with awarding Scarce Medical Specialist contracts are the result of such contracts being awarded under 38 USC 8183, Enhanced Sharing. Current policy for enhanced sharing does not fully describe how to negotiate and administer these contracts. Previous Scarce Medical Specialist contracting policy was covered in VHA Directive 96-039, which expired in May 2001. A subgroup of the Acquisition Issues Task Group is working on reissuing this directive and providing additional relevant information to help facilities avoid improperly awarding Scarce Medical Specialist contracts.

Controls Over the Fee-Basis Program

VHA has implemented all but one of the recommendations from the June 1997 report, *Audit of Internal Controls over the Fee-Basis Program.* The remaining recommendation deals with

establishing guidelines for contracting home health services and providing contracting officers with benchmark rates for determining the reasonableness of charges. VHA's Geriatrics and Extended Care Strategic Health Care Group is finalizing a directive, Purchasing Home Care and Hospice Services from Community Agencies for Enrolled Veterans, and VHA is working with the OIG to implement this final recommendation.

10. Human Capital Management

Human capital management (HCM) is a major challenge for the Department, resulting from a high number of employees projected to become retirement-eligible over the next 5 years. Given the significant size of VA's workforce, there are also significant dollar outlays associated with addressing this challenge effectively. GAO has also identified strategic HCM as a Governmentwide "high risk" area.

Risks associated with not addressing VA's HCM include:

- Patient injury or loss of life.
- Program failure.
- Significantly reduced effectiveness.
- Significantly reduced efficiency.

VHA Nurses

The VA Office of Human Resources Management (HRM) reported in FY 2001 that registered nurses are the largest segment of health care workers within the Department. VA employs approximately 35,000 registered nurses and nurse anesthetists. VAMCs are having difficulty recruiting nurses in specialty fields and some VAMCs find it difficult to recruit and retain licensed practical nurses and nursing assistants. According to HRM, 12 percent of the VA nursing population is eligible to retire. Each year, approximately 4 percent more will be eligible to retire. HRM reports that by 2005, 35 percent of the current nursing workforce will be eligible for retirement.

Recent GAO reports point to the importance Congress has placed on this issue. The following is a list of recent GAO reports and quotes of pertinent statements in those reports:

- January 2001, High Risk Series - "A national nursing shortage could adversely affect VA's efforts to improve patient safety in VA facilities and put veterans at risk."

- July 2001, Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors - "The large numbers of registered nurses that entered the labor force in the 1970s are now over the age of 40 and are not being replenished by younger registered nurses...Job dissatisfaction has also been identified as a major factor contributing to the current problems of recruiting and retaining nurses...Demand for nurses will continue to grow as the supply dwindles...The future demand for nurses is expected to increase dramatically when the baby boomers reach their 60s, 70s, and beyond...."

- May 2001, Nursing Workforce: Recruiting and Retention of Nurses and Nurse Aides Is a Growing Concern - "With the aging of the population, demand for nurse aides is expected to grow dramatically, while the supply of workers who have traditionally filled these jobs will remain virtually unchanged."

- August 2001, Health Workforce: Ensuring Adequate Supply and Distribution Remains Challenging - "While current data on supply

and demand for many categories of health workers are limited, available evidence suggests emerging shortages in some fields, for example, among nurses and nurse aides."

Current Status: VHA formed a National Succession Planning Task Force to address VHA's changing workforce. According to the Task Force's August 2001 draft report on VHA Succession Planning, "VHA faces a leadership crisis unprecedented in its history. With 98 percent of our senior executives eligible to retire by 2005 and other key clinical and administrative cadres facing similar turnover, it is paramount that we quickly focus on both developing our new leaders as well as replacing key employees throughout our organization."

The Task Force's draft report lists recommendations in seven major categories: (i) benchmarking, (ii) workforce assessment, (iii) employee morale and satisfaction, (iv) short-term steps, (v) progression planning, (vi) legislative initiatives, and (vii) organizational infrastructure. The report states that attracting, developing, and retaining a well-qualified workforce at all levels of VA's organization is paramount to ensure VA's ability to provide quality care to our veteran population. Recent GAO reports on management challenges cite a shortage of VHA nurses and difficulty in properly training and recruiting VBA claims processors as challenges for the Department.

VBA Claims Processing

The Secretary tasked a Claims Processing Task Force in May 2001 to identify the challenges VBA faces with timely and accurate claims processing. The Task Force reported that during the past decade the number of employees in VBA "dropped slightly while workload increased dramatically." The Task Force also reported that VBA reduced the availability of skilled labor for processing claims while diverting experienced staff to implement new processes that were poorly managed.

Although Congress has provided VBA an increase in funding to pay for 800 employees in each of the last 2 years, VBA does not have an integrated training plan and program. The Task Force reported that VBA's Office of Employee Development and Training is not equipped to develop a comprehensive training plan. The report concludes that VBA has not put together the needed training infrastructure. The report also states that VBA's current hiring pattern is not the result of any strategy and is not integrated with any business plan. The report identifies 13 separate points in its recommendation for a fully integrated training plan and program, which includes the creation of a fully integrated training infrastructure.

Current Status: The OIG has not issued recent national audits on HCM. However, we have identified resource shortages in Combined Audit Program (CAP) reviews.

VA's Program Response

VHA Nurses

National nursing shortages continue to be a priority issue for the entire health care industry. VHA maintains an ongoing, active recruitment process. There is no indication that the quality of care in VA medical centers has been adversely affected by nursing staff limitations.

In response to this challenge, the Department established the Office of Workforce Planning in FY 2001 in order to devote full-time resources to developing and implementing a comprehensive workforce planning initiative that will enable VA to remain a competitive employer and provider of quality services to America's veterans. As part of this initiative, VA developed a Departmental

Workforce Analysis and 5-Year Restructuring Plan that details demographics, skill assessments, human capital challenges and accomplishments, and strategies that demonstrate VA's commitment to becoming more citizen-centered.

In order to address VA's human capital challenges, we have developed the Department of Veterans Affairs Workforce and Succession Plan. This plan articulates VA's corporate vision for workforce and succession planning and identifies specific strategies to address recruitment, retention, and development issues.

VBA Claims Processing

In response to the challenges in the areas of claims processing and succession planning, VBA has undertaken a number of initiatives designed to build human capital across the organization. A highly successful multi-year nationwide recruitment program yielded over 2,000 entry-level employees primarily in the Compensation and Pension business line. The influx of new employees in advance of expected high retirement levels among senior employees has ensured adequate time for skills development and knowledge transfer through training and mentoring. To support training and mentoring programs, VBA has obtained a regulatory flexibility from the Office of Personnel Management allowing reemployment of experienced retirees without reduction in their annuities. This initiative has reduced the need to move experienced employees into training roles from direct claims work. A third approach involved a study (begun summer 2001) to develop a system of leadership competencies for use in selection, development and succession planning for executive, mid-level management, and first-line supervisory positions. Initiatives involving VBA's human resources capacity included a 2001 contractor study of the human resources function, structure, and alignment; and week-long training conferences for the entire VBA human resources community in August 2000 and 2002. Finally, the annual Directors' Conference in September 2001 focused on "High Performance in Leadership Development," through a week-long program of learning, discussion, and study of recruitment, change management, information technology, development, succession planning, performance management, employee satisfaction, and recruitment.

A Training Task Team convened to respond to the 13 Task Force recommendations and recently briefed VBA management on a series of findings and action recommendations. The team's recommendations were divided into five categories: evaluating current training; instructor selection and certification; establishing skill competency and job certification criteria; delivering training; and structure. The Office of Employee Development and Training (ED&T) completed milestones in several of the categories. These include completion of an assessment of previous training, establishment of an instructor certification process and the training of a first class of instructors, and completion of a design plan for broadcasting capability at the Veterans Benefits Academy. Milestones completed by the Compensation and Pension Service and ED&T include submission of proposed organization structures for training and a schedule to review the skill requirements and competencies for each grade level within the VSR and RVSR job series, which will establish the foundation for a training plan for each employee.

VBA successfully concluded an 18-month SES Candidate Development Program for 16 new senior leaders. The program was endorsed by the U.S. Office of Personnel Management and was adopted by the Department as the framework for a departmentwide program announced late in 2001. Completion of a systematic path of leadership training continues. VBA led a VA-wide team to produce an Assistant Director Development Program.

Management Challenges Identified by the General Accounting Office

1. Access to Quality Health Care

Over the past several years, VA has undertaken many initiatives to improve veterans' overall access to VA-provided health care, such as shifting its emphasis from inpatient to outpatient primary care and increasing the number of outpatient clinics it operates. VA has also undertaken efforts to improve the quality of care it provides, including the introduction of patient safety initiatives. However, several areas require continued emphasis if VA is to achieve its goals. For example, VA cannot ensure that veterans receive timely care at VA medical facilities, nor can it ensure that it has maintained the capacity to provide veterans who have spinal cord injuries, serious mental illnesses, or other special needs the care that they require, as mandated by Congress. VA must also assess its capacity to provide long-term care for its aging veteran population and respond to emerging health care needs, such as treating veterans for hepatitis C. At the same time, VA is facing a potential shortage of skilled nurses which, if nationwide projections for the next several years bear out, could have a significant impact on VA's quality of care initiatives.

Current Status and Future Plans

Access

VA has taken significant steps to improve veterans' access to health care. For the period October 1, 2000 through September 30, 2001, a total of 67 community-based outpatient clinics (CBOCs) were opened across the country to maintain the emphasis on outpatient primary care. VHA has also placed a high priority on full implementation of telephone access to care (nurse advisor). In FY 2001, all but one VISN achieved full Network-wide implementation of this important facet of access. The remaining VISN plans to provide "24/7" telephone care by March 2002.

Waiting Times

In response to concerns about waiting times, VA established strategic targets for the time it takes veterans to get an appointment with a VA provider (either primary care or specialty care) and the time they spend waiting in a provider's office. As part of its strategy to reduce waiting times and meet service delivery targets, VA has entered into short-term contracts with consultants to help reduce the backlog of specialty appointments. By improving waiting times, through process improvements, physical plant renovations, pharmacy refills by mail, and other means, VHA will effectively improve patient satisfaction with the quality of their health care.

Quality and Patient Safety

Quality management leadership at all levels has been strengthened. The Office of Quality and Performance is now fully staffed. Network Quality Management program personnel qualifications, responsibilities, and functions have been clearly delineated in standardized position descriptions and consistent position titles.

VHA is committed to continuously improving the culture of patient safety in its health care facilities. VA uses root cause analysis (RCA) to develop a good understanding of the causes of safety problems through identification of basic or contributing causal factors that underlie variations in performance associated with adverse events or "close calls" involving VA patients.

VHA's establishment of the National Center for Patient Safety (NCPS) and national training on the principles of root-cause analysis represent an

aggressive response to previous concerns. The focus that NCPS has placed on the issue of patient safety and on resolving long-time patient vulnerabilities provides sentinel capabilities toward making sure that VA patients receive proper care in a safe environment.

In FY 2001, VHA met the performance goal for having root cause analyses in a correct format and completed within the appropriate time (45 days). Timeliness is important, because the longer it takes to complete an RCA, the longer it is before preventive corrective actions can be implemented. In FY 2002, to continue emphasizing new methods in ensuring patient safety, this performance measure will be replaced with one that will measure the success of implementing bar code medication administration.

VHA achieved its goal of providing 20 hours of continuing education on patient safety to front-line providers of patient care. This goal, included in each Network director's performance standards, was achieved through satellite video and computer-based self-teaching modalities, which maximized cost effectiveness.

Treating Veterans with Special Disabilities

The Department has adopted several performance measures to help assess the treatment of veterans with special disabilities. For example, VHA is focused on promoting the health, independence, quality of life, and productivity of individuals with spinal cord injuries (SCI). Similarly, we view discharge to non-institutional, community living as a positive health outcome. Consequently, one of VHA's primary performance measures is the proportion of discharges from SCI Center bed sections to non-institutional settings. Performance in FY 2001 was 98 percent.

In 1996, Congress provided a mandate in its Eligibility Reform legislation (P.L. 104-262) to ensure that we maintain nationwide capacity to deliver specialized care to disabled veterans with spinal cord injuries and diseases, blinded veterans, veterans with amputations, and those with severely chronic, disabling mental illnesses. P.L.104-262 also required the publication of data in an annual report (the "Capacity Report") to Congress demonstrating VA's compliance with the provisions of this mandate.

On November 2, 2000, a coordinator for special disabilities was appointed by the Under Secretary in response to a General Accounting Office recommendation to:

- Address underlying dissatisfaction from stakeholders and oversight groups with VA's annual Eligibility Reform report to Congress.

- Structure and develop a rational, viable action plan to improve database accuracy and nationwide reporting consistency for special disability patient care, staffing and demographic data for inclusion in the OIG's annual report to Congress.

In addition, in May 2001, the FY 2000 Capacity Report was published in a new narrative format designed to place the accountability for interpretation of data for each special disability with program officials in VHA and their clinical service chiefs in the field. Data table formats remained the same to maintain continuity between FY 1996 (the year required by Congress) and FY 2000.

In July 2001, eight work groups representing each special disability category were created, co-chaired by a VISN clinical manager and a Patient Care Services Program director/Strategic Health Group chief consultant. Work groups are responsible for explaining the reason for incomplete data capture

in VHA databases regarding clinical care provided for special disability patients.

General Findings and Conclusions - Capacity Report 2000

Nationwide capacity has been maintained or improved for workload measures in seven of eight specialties. Analysis of Allocation Resource Center (ARC) data from all VISNs shows evidence of a wide variation in capacity for special disabilities among VISNs.

- VHA's corporate database from FY 1996 to FY 2000 published by ARC is not considered to be accurate by certain VSOs and VA's federal advisory committees. The data for mental health specialties, especially substance abuse, is considered to be incomplete and reflects negatively upon these high-volume, high-cost specialties.

- Significant advances in data-gathering and recording processes since September 30, 2000, have substantially improved the validity of capacity data (beds and FTE) for the Spinal Cord Injury and Disorders (SCI&D) program.

- However, in other specialties, the implementation of VHA policies, current definitions, and "counting rules" for workload makes it difficult to ensure that special disability patient care data are correctly and uniformly entered into local hospital/clinic databases.

- More work is needed to better capture data on special disability patients. Patient Care Services is actively working with clinical managers to preclude this problem.

Positive Actions and Accomplishments Since the Last Capacity Report

- The Paralyzed Veterans of America (PVA), in general, has expressed satisfaction with the effectiveness of programmatic directives from the Under Secretary for Health and the compliance of field sites with the directives. Stakeholders such as the PVA have worked closely with VHA during the past year to improve the accuracy of Spinal Cord Injury data submitted from the SCI&D program using a joint VHA/PVA survey.

- For all other programs except Substance Abuse, VHA can document that it has maintained or improved its workload capacity for its special disability programs. For example, a decrease in amputation rates indicates more aggressive treatment and better preventive care for veterans.

- Appointment of a clinical coordinator in Patient Care Services has created a new dialogue and a bi-directional information exchange between VISN clinical managers and VA Central Office to identify the causes of data differences among and within VISNs.

- VHA has issued policy establishing centralized review of proposed changes in mental health and SCI&D programs in the field. This has markedly improved oversight of these special disability programs by the national program offices as well as the accuracy of available information.

Shifting Health Care Needs and Workforce Issues

Substantial planning, effort, and resources will be required as VA positions itself to meet the increasing health care needs of the expanding population of elderly veterans. As noted, the population projections emphasize our demographic

imperative. According to the Long-Term Care Planning Model, the enrolled population over age 85 will triple between fiscal years 2000 and 2010.

As authorized in PL 106-117, VA is conducting a 3-year pilot study of assisted living for veterans. The pilot site, selected through a competitive process, includes the four states within VISN 20, Pacific Northwest. A report on the outcomes of the pilot will be prepared for Congress in 2004.

VA officials estimate that as much as 6.6 percent of its health care enrollees are infected with the hepatitis C virus. This rate is three times higher than that of the general U.S. population. Over the past 2 years, VA identified health care funding to screen patients for hepatitis C risk factors, develop treatment protocols, and create a public health awareness campaign. In addition, VA adopted appropriate performance measures for screening and testing patients evaluated for risk factors for hepatitis C.

In response to concerns about a national nursing shortage, VA is engaged in multiple efforts to assess the adequacy of its current nursing workforce and plan for the future. Recent legislation authorizing higher salaries for VA nurses could help in these efforts. The Nursing Workforce Planning Group (whose members include representative nurses from a variety of roles, a Nurses Organization of Veterans Affairs representative, labor partners, hospital administrators and human resources experts) completed a report that examines the impact of the nursing shortage on VA and current barriers to VA medical center recruitment and retention of nurses in a competitive marketplace. The report contains a reference guide for the optimal use of current hiring and pay authorities and also makes recommendations for both legislative and non-legislative initiatives to address the nursing shortage.

VHA employs a diverse and knowledge-based workforce comprised of individuals with a broad spectrum of technical and program skills and institutional memory; a large proportion of this workforce is reaching retirement age. VHA has begun a substantial succession planning effort – encompassing all processes and activities – to ensure that current and future missions are supported by the highest quality workforce. To this end, VHA's Succession Planning Committee has analyzed current and future workforce needs and capacities and recommended actions to address immediate and long-term issues and institute Human Resources strategic planning as an integral component of VHA's annual strategic planning process.

A Web site (http://vaww.va.gov/succession/) was established to allow all VA employees access to information on succession planning in VHA. The site includes the results of a survey on succession planning activities in every VISN and in the Central Office; tools for conducting analyses; information on the Succession Planning Committee; study results; a library of documents; and links to other related sites.

2. Health Care Resource Utilization

To expand care to more veterans and respond to emerging health care needs, VA must continue to aggressively pursue opportunities to use its health care resources–including its appropriation of over $20 billion–more wisely. VA has reduced its per patient costs–one of its key performance measures–by 16 percent, but it could achieve additional efficiencies by realigning capital assets and human capital based on changing demographics and veterans' health care needs. For example, VA needs to further modify its infrastructure to support its increased reliance on outpatient health care services and expand its use of alternative methods for

acquiring support services, such as food and laundry. The Department spends as much as one-quarter of its annual health care budget to operate and maintain about 4,700 buildings and 18,000 acres of property. VA also needs to pursue additional opportunities with DoD to determine cost-effective ways to serve both veterans and military personnel, including sharing services and facilities. In addition, VA must ensure that it collects the money it is entitled to from third-party payers for health care services provided to veterans whose conditions are not service-connected.

Current Status and Future Plans

Asset Restructuring

VA's capital infrastructure has been designed, for the most part, as a "hospital-based" delivery system with a focus on inpatient acute care and supporting services. This configuration no longer reflects VHA's current delivery of care, as VA health care delivery has evolved into an integrated delivery system with greatly expanded outpatient services. The costs to maintain and operate the existing VA capital infrastructure are substantial, diminishing the availability of resources that could be devoted to direct patient care services. Future realignments of VA's capital infrastructure, including contracting for acute hospital care in locations where there is not sufficient workload and establishing new facilities for provision of outpatient care, will yield improved access, efficiencies and service to veterans.

The Capital Asset Realignment for Enhanced Services (CARES) program is designed to assess veteran health care needs in VHA VISNs, identify service delivery options to meet those needs for the future, and develop an associated capital asset realignment plan that ensures the availability of high-quality health care in the most accessible and cost effective manner, while minimizing impacts on staffing and communities and on other VA missions. Through the CARES process, VISNs will develop plans for capital asset restructuring that are based on practices in health care delivery, demographics, strategic plans, and assessments of the existing as well as future capacity of physical plants to deliver accessible, quality health care.

VA also has an on-going infrastructure maintenance program (for VHA it is non-recurring maintenance; while in VBA and NCA it is general operating expense) to address periodic system renovations and replacements. In addition, the Facility Condition Assessment evaluation (approximately 50 percent complete at this time) will provide current information on VHA's physical plant condition. This information will be a valuable tool for medical centers to use in strategic planning for future capital investments.

DoD and VA Cooperation

In FY 2001, President Bush established a top-level VA-DoD Task Force designed to find ways to improve health care in both agencies and to determine the existence of greater opportunities for sharing as well as buttressing a VA mission to serve as primary backup to DoD in times of national emergency. To date, the Task Force has developed a working agenda in response to the President's Executive Order. The Task Force meets monthly and has developed a working agenda in response to the President's Executive Order to identify ways to improve benefits and services, and review barriers and challenges that impede coordination between the Departments. Seven work groups have been formed to review a variety of issues: Benefit Services, Acquisition and Procurement, Facilities, Information Management/Information Technology, Leadership and Productivity, Pharmaceuticals, and Resources/Budget Process.

Ongoing activities that predate this Executive Order include:

- The Persian Gulf Veterans Coordinating Board was established in January 1994 under the authority of United States Code (U.S.C.) Title 31, section 1535. This Board has established three subgroups – focusing on research, clinical issues, and disability compensation.

- The Military and Veterans Health Coordinating Board (MVHCB) was established in December 1999, with three working groups – focusing on research, health and health risk communications. The second work group is tasked with monitoring and coordinating interagency activities related to force health protection and medical surveillance. The last of these has developed a public-academic partnership with The George Washington University and the Centers for Disease Control and Prevention, which are in the forefront of disseminating needed information regarding anthrax and other biological contaminants.

- Force Health Protection Initiative: On November 8, 1997, President Clinton directed the "...Departments of Defense and Veterans Administration to create a new Force Health Protection Program...." This initiative has been enfolded in the MVHCB's subgroup described above and will "...provide every soldier, airman and marine with comprehensive, life-long medical record of all illnesses and injuries they suffer, the care and inoculations they receive and their exposure to different hazards."

- Joint Ventures: (a) the New Mexico VA Health Care System partners with the 377th Air Force Medical Treatment Facility in Albuquerque; (b) the El Paso VA Health Care System operates an outpatient facility adjacent to the William Beaumont Army Medical Center; (c) the Mike O'Callaghan Federal Hospital in Las Vegas, Nevada, provides services to both VA and Air Force beneficiaries; (d) Alaska VA Health Care System and Anchorage Regional Office and the 3rd Medical Group from Elmendorf Air Force Base (AFB) operate a VA/DoD replacement hospital; (e) Navy and VA occupy an outpatient care facility in Key West, Florida; (f) VA operates an ambulatory care center and leases a psychiatry ward from Tripler AFB in Honolulu, Hawaii. Tripler also provides inpatient medical, surgical and specialty outpatient care for DoD and VA beneficiaries while VA's Center for Aging provides both with long-term care, rehabilitation and home-based primary care. In addition, an enhanced-use lease with US Vets provides shelter and programs for homeless veterans at Barber's Point Naval Station (which VA obtained through DoD's Base Closure Program); and (g) in Fairfield, California, Travis AFB provides care to VA inpatients and provides same-day surgery within the David Grant Medical Center. The Air Force also provides outpatient specialty and ancillary support services. VA was leasing outpatient space until late 2000 when it opened its own outpatient clinic. The Air Force also operates two TRICARE satellite clinics in the Sacramento area, both of which are located in VA facilities.

- VA/DoD Medical Research: Historically this program has supported biomedical research for a wide variety of health problems experienced by active duty and veteran military personnel. The currently funded collaborative research program includes a multi-site clinical study exploring the epidemiology of amyotropic lateral sclerosis (Lou Gehrig's Disease) among Persian Gulf Veterans, as well as other studies.

- Health Information Management and Technology: Chief Information Officers from the Military Health System and VHA meet on

a continuing basis to explore, assess, develop, and monitor sharing initiatives. Both CIOs are members of and report to the VHA/DoD Executive Council. These officers are also engaged in a host of other interagency efforts.

- Other sharing activities: (1) the Army established an infirmary service at the VAMC in Richmond, Virginia; (2) the 81st Army Reserve Regional Support Command has negotiated regional agreements with more than one-third of VHA's VISNs to provide physical examinations, dental screenings and immunizations to reservists; (3) the Military Medical Support Office in Great Lakes, Illinois, assumed responsibility for managing the Remote Dental Program for Air Force, Army, Navy, Marines and Air National Guard personnel as well as four VISNs' beneficiaries; (4) VHA CBOCs occupy clinic space provided by military facilities in Louisville, and Fort Knox, Kentucky, among other locations (see above); (5) the Walter Reed Army Allergen Extract Laboratory in Washington, D.C. provides delivery of diagnostic and therapeutic allergen extracts to 29 VAMCs and outpatient allergy clinics; (6) VA and TRICARE – by prior agreement, over 71 VAMCs utilize funds generated by TRICARE patients to help provide benefits to VA beneficiaries, and VA has signed agreements with all 5 TRICARE mental health subcontractors; (7) there are over 155 VA/DoD agreements involving education and training support to DoD units and reservists.

Third-Party Collections

VA Secretary Principi directed the Under Secretary for Health to develop a revenue cycle improvement plan. The plan describes the vision of the VHA Revenue Program, outlines an action plan for improved performance, and defines performance measures and goals that stress standardization of policy, technology, data capture, measurement, training and education, accountability, and achievement. This plan also outlines recommended actions required to improve the core business processes of the revenue cycle. These action items fall within five process areas: Patient Intake, Documentation, Coding, Billing, and Accounts Receivable.

The Revenue Enhancement Work Group and Steering Committee have identified 24 major recommendations that require action in order to bring VHA's revenue operation to the next level of success in improving collections. VHA will actively and aggressively monitor these identified areas to ensure that all possible areas of improvement have been achieved. VHA will take prompt action to provide assistance to any Network or medical center that is not performing consistent with these expectations. Based on the collection performance experienced in FY 2001, with collections totaling over $770 million, we anticipate being able to meet or exceed the collection estimate of $1.05 billion in FY 2002.

3. Compensation and Pension Claims Processing

VA must also continue to seek ways to ensure that veterans are compensated for reduced earning capacity due to disabilities sustained, or aggravated, during military service. VA has had long-standing difficulties in ensuring timely and accurate decisions on veterans' claims for disability compensation. VA has improved its quality assurance system in response to GAO's recommendations, but large and growing backlogs of pending claims and lengthy processing times persist. Moreover, veterans are raising concerns that claims decisions are inconsistent across VA's regional offices.

VA has taken steps to improve its information systems, performance measures, training strategies, and processes for reviewing claims accuracy. However, VA also needs better analyses of its processes in order to target error-prone types of cases and identify processing bottlenecks–as well as determine if its performance goals are realistic. VA also needs to be vigilant in its human capital strategies to ensure that it maintains the necessary expertise to process claims as newly hired employees replace many experienced claims processors over the next 5 years.

Current Status and Future Plans

VBA is currently addressing the Compensation and Pension Claims Processing issues as noted on above response (item number 3), under the challenges identified by VA's Inspector General.

4. Management Capacity

VA has more work to do to become a high-performing organization and increase veterans' satisfaction with its services. It must revise its budgetary structure and develop long-term, agency-wide strategies for ensuring an appropriate information technology (IT) infrastructure and sound financial management. If its budgetary structure linked funding to performance goals, rather than program operations, VA and the Congress would be better positioned to determine the Department's funding needs. VA's IT strategy, which aims to provide veterans and their families coordinated services, must be successfully executed to ensure that VA can produce reliable performance and workload data and safeguard financial, health care, and benefits payment information. Similar to most other major agencies, VA's financial management strategies must ensure that its systems produce reliable cost data and address material internal control weaknesses and Federal Financial Management Improvement Act requirements.

Current Status and Future Plans

Performance-based Budgeting

VA and OMB staff jointly developed a proposal to restructure the Department's budget accounts. The goal of this account restructuring effort is to facilitate charging each program's budget accounts for all of the significant resources used to operate the program and produce its outputs and outcomes. The benefits of budget account restructuring are: (1) to more readily identify program costs; (2) to shift resource debates from inputs to outcomes and results; (3) to eventually make resource decisions based on programs and their results rather than other factors; and (4) to improve planning, simplify systems, enhance tracking, and focus on accountability. We are on track to implement the new structure with the FY 2004 budget.

Financial Management

In FY 2000, VA again received an unqualified opinion on the consolidated financial statements for FY 2000 and 1999. In addition, VA continued to make substantial progress in correcting material internal control and other management and operational controls reported by GAO. The material internal control relating to fund balance with Treasury was removed. VA continued to implement significant improvements in accounting for the Housing Credit Assistance program, which was converted to VA's core financial management system, FMS. In addition, to correct material weaknesses in information technology security, the Secretary is personally setting expectations for improvement at all levels; funding for cyber security initiatives that cross Administrations is beginning. Individual and collective cyber security responsibilities and accountability are being identified and assigned. While major improvements in financial management have been achieved, VA is committed to addressing and correcting the remaining areas identified by GAO.