Major Management Challenges Identified by the OIG

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

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

- ***Key actions taken*** in 2007 in response to the challenges identified by the OIG
- ***Key actions planned*** for 2008
- ***Anticipated impacts*** of the key actions
- ***Estimated resolution timeframe***

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

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

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Memorandum

Department of Veterans Affairs

Date: July 12, 2007

From: Inspector General (50)

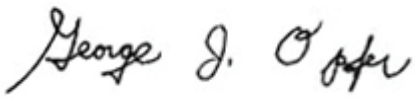
Subj: FY 2007 Performance and Accountability Report

To: Secretary of Veterans Affairs (00)

1. Attached is the Office of Inspector General (OIG) update of the most serious management problems facing VA, for use as part of the FY 2007 Performance and Accountability Report (PAR). Our staff have coordinated this year so that VA may publish the full OIG report on major management challenges in the PAR.

2. The *Reports Consolidation Act of 2000*, Public Law 106-531, requires OIG annually to submit this statement to the Department. The law also states the agency may comment on, but may not modify, the OIG statement. Please ensure that all suggested changes made by the Department are provided to OIG for review prior to incorporating the changes in the PAR.

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



GEORGE J. OPFER
Inspector General

Attachment

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

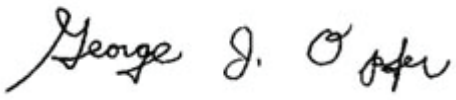
Foreword

America depends on VA. At the same time that thousands of men and women returning from the war being fought in Afghanistan and Iraq are turning to VA for health care and benefits to help them get on with their lives, nearly two-thirds of American men over 85 are now veterans, relying more than ever on VA. VA health care and benefits delivery must be made as effective and efficient as possible, which requires that VA support services—financial management, procurement practices, and information management—must also be strong and secure.

The Office of Inspector General (OIG) seeks to help VA become the best-managed service delivery organization in Government. OIG audits, inspections, investigations, and Combined Assessment Program (CAP) reviews recommend improvements in VA programs and operations, and act to detect and deter waste, fraud, and abuse. Each year, as required by the *Reports Consolidation Act of 2000*, Public Law 106-531, OIG provides VA with an update summarizing the most serious management problems identified by OIG work and other relevant Government reports, as well as an assessment of the Department's progress in addressing them.

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

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



GEORGE J. OPFER
Inspector General

FY 2007 MAJOR MANAGEMENT CHALLENGES

MAJOR MANAGEMENT CHALLENGES

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

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

The following summaries present the most serious management problems facing VA in each area and assess the Department's progress in overcoming them. While these issues guide our oversight efforts, we continually reassess our goals and objectives to ensure that our focus remains relevant, timely, and responsive to changing priorities. *(On these pages, the words "we" and "our" refer to OIG. OIG comments in this report are up-to-date as of November 1, 2007; VA responses were submitted in September 2007. Years are fiscal years (FY) unless stated otherwise.)*

OIG CHALLENGE #1: HEALTH CARE DELIVERY

-Strategic Overview-

Most critical among the many challenges VA faces is the transition and quality of health care for veterans, literally a life-and-death concern. In 2008, VA expects to treat 5.8 million unique patients, including Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans, as well as increasing numbers of older World War II, Korea, and Vietnam veterans. The Veterans Health Administration (VHA) 2008 budgetary resources request of $36.6 billion for medical care programs provides health care for an increase of 125,000 Priority 1 through 6 veterans, which is 3.3 percent above 2007 estimates. OIG will continue to assess the quality of care at delivery points throughout VA, with a special emphasis on returning OIF/OEF veterans and the transition of care from military service to VA.

VA is justly proud of its strong reputation in health care and medical research, and OIG is equally proud of its own contributions to helping VA maintain and improve these capabilities. OIG oversight focuses on a variety of management and program controls, and the medical care system infrastructure. At a time when the adequacy of VA health care funding is debated, the management of health care delivery is as important a focus for OIG as the issues of quality of care.

OIG Challenge #1A: Quality of Care

Overall, the quality of VA health care is very high and higher than its private sector counterpart. This commendable level, however, is not without continuing challenges. For example, OIG reviews have shown unacceptably high waiting times and delays remain in obtaining subspecialty procedures and subspecialty medical diagnoses. OIG continues to identify inaccurate reporting of

waiting times and patient waiting lists, a problem on which OIG reported and sought corrective action since 2005. OIG will continue to review medical outcomes and quality of care issues in its health care inspections and CAP reviews. VHA has generally responded promptly to correct quality of care deficiencies identified by OIG work, but ensuring high quality health care through the vast VA system in varied settings will remain a challenge. OIG will continue its oversight of care provided in all settings to ensure, for example, that eldercare and Community Based Outpatient Clinics (CBOCs) care are of the same high quality as inpatient medical center care. Analogously, we will continue to evaluate whether care in medical centers in rural, urban, and suburban locations is consistent and of consistently high quality.

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

ESTIMATED RESOLUTION TIMEFRAME: FY 2008 AND BEYOND

Measuring the Quality of Health Care Provided	
Key FY 2007 Actions	Anticipated Impacts
Conducted year-end **assessment** of the **quality of care provided in CBOCs and VA medical centers.** Results indicate that the same high quality of care was provided in both care settings.	Ensure that patients treated in CBOCs receive the same quality of care as those treated in VA medical centers. Identify areas in need of improvement as well as areas of high performance to continuously improve the quality of care throughout VA medical facilities and become a high performance organization. Ensure the quality of care provided to patients and compliance with selected VA directives and accreditation standards.
Compared **quality of care between patients living in urban versus rural areas**. Of 51 clinical quality measures used, there was no meaningful difference in the scores of almost all measures between the two patient groups.	Ensure that patients living in rural areas receive the same access to and quality of care as those living in urban areas. Identify areas in need of improvement as well as areas of high performance to continuously improve the quality of care throughout VA medical facilities and become a high performance organization. Ensure the quality of care provided to patients and compliance with selected VA directives and accreditation standards.
Analyzed **more than 100 quality measures** on a quarterly basis, with focus in such areas as access, prevention/health promotion, cardiovascular disease, mental health, and OIF/OEF servicemembers and veterans.	Identify areas in need of improvement as well as areas of high performance to continuously improve the quality of care throughout VA medical facilities and become a high performance organization. Ensure the quality of care provided to patients and compliance with selected VA directives and accreditation standards.

Measuring the Quality of Health Care Provided	
Key FY 2007 Actions	Anticipated Impacts
Quality is also evaluated in **special veteran populations** such as women, mentally ill, spinal cord injury, OIF/OEF, and others.	Ensure that special veteran populations have access to VA health care, and VA programs are responsive to their unique circumstances and special needs. Identify areas in need of improvement as well as areas of high performance to continuously improve the quality of care throughout VA medical facilities and become a high performance organization. Ensure the quality of care provided to patients and compliance with selected VA directives and accreditation standards.
Surveyed patient satisfaction that included an expanded sample of **10,000 OIF/OEF veterans**.	Initiate patient satisfaction improvement efforts in areas needing improvement, such as access to care and seamless transition of OIF/OEF patients from DoD to VA care.

Improving the Processes of Care	
Key FY 2007 Actions	Anticipated Impacts
Continued efforts to **reduce delays** in completing subspecialty diagnoses and procedures. Progress was made to improve **processes of care** for colorectal cancer, among others. The National Colorectal Cancer Diagnosis Improvement Project facilitated measurement and improvement efforts through sharing of information on a national listserve, monthly national conference calls, and the Systems Redesign Web site. Also initiated a Colorectal Cancer Care Treatment Collaborative to measure and improve timeliness and reliability of treatment.	Improve access to care and quality of care. Reduce wait times.

Measuring the Quality of Health Care Provided	
Key FY 2008 Actions	Anticipated Impacts
Continue using strategies described above for 2007.	Identify areas in need of improvement as well as areas of high performance to continuously improve the quality of care throughout VA medical facilities and become a high performance organization. Ensure the quality of care provided to patients and compliance with selected VA directives and accreditation standards.

Improving Access to Care	
Key FY 2008 Actions	Anticipated Impacts
Complete an analysis of VA's scheduling processes, including **electronic waiting lists** and waiting times reporting, and develop an action plan. Continue to take other important actions: ○ Take steps to implement a proposed new patient scheduling software package. ○ Improve waiting time metrics. ○ Develop standardized tools to improve reporting accuracy systemwide. ○ Address training and career development issues for facility scheduling clerks.	Improve access to care and quality of care. Reduce wait times.

OIG Challenge #1B: Electronic Medical Records

VA has deservedly received recognition for establishing the gold standard in medical care in its electronic medical records system. The system is not perfect, however, as OIG reviews frequently find local business rules which permit editing of information in patient records after they have been signed, rather than leaving the official record as is and simply appending updates or corrections. We continue to report in CAP reviews the need to comply with applicable VHA policies designed to ensure complete and accurate medical records. With the increased attention on data security and the centralization of resources and authority under the Department's Chief Information Officer (CIO)—which OIG acknowledges were needed—we will continue our oversight of VA's electronic medical records to ensure this cutting edge technology remains innovative and flexible to adapt to VA's health care and benefits needs while maintaining high quality care for veterans.

Related to the VA electronic medical records issue is VA's access to military medical records of the veterans VA treats. Due to the importance and volume of OIF/OEF veterans being transitioned from military to VA health care, any problems the Department of Defense (DoD) experiences pose significant challenges to VA in caring for these new veterans. These DoD issues, although outside VA's exclusive control to change, create a management challenge to VA when VA assumes the responsibility for the veteran's care. Problems include access to the DoD records in real time as well as the lack of standardized medical records among the uniformed services. The President and Congress have emphasized the need to coordinate VA and DoD programs and systems, and the problem is perhaps most acute at VA points of care where the VA provider is unable to access the veteran patient's prior or concurrent military medical records. We encourage VA's efforts to work with DoD and the Congress to overcome any interdepartmental obstacles in VA and DoD that hinder the delivery of world-class care that veterans deserve.

VA's Program Response to OIG Challenge #1B: Electronic Medical Records

ESTIMATED RESOLUTION TIMEFRAME: FY 2008 AND BEYOND

Background

In 2006 VA's model system of electronic health records, developed with extensive involvement of front-line health-care providers, won the prestigious "Innovations in American Government Award." The annual award, sponsored by Harvard University's Ash Institute for Democratic Governance and Innovation at the Kennedy School of Government and administered in partnership with the Council for Excellence in Government, honors excellence and creativity in the public sector.

Electronic health records provide numerous benefits in cost, quality, and access to care. The cost of maintaining the system is $80 per patient per year, less than the cost of one unnecessarily repeated lab test. In the last 10 years, the efficiencies of the Veterans Health Information Systems and Technology Architecture (VistA) have offset cost increases associated with a 100 percent increase in the number of veterans receiving VA care. For example, VistA has helped VA save 6,000 lives by improving rates of pneumonia vaccination among veterans with emphysema, cutting pneumonia hospitalizations in half, and reducing costs by $40 million per year. Patient waiting times have declined while customer service improved, and access to care has increased because of on-line availability of health information.

Patient Data Exchange With DoD	
Key FY 2007 Actions	Anticipated Impacts
Completed an interface to permit all VA and DoD facilities to have **bidirectional access** to inpatient and outpatient pharmacy data, laboratory results, radiology report data, and allergy information.	Provide better health care for shared patients (that is, those who receive care from both departments) through the real-time, two-way view of inpatient and outpatient health data from existing systems at all VA and DoD sites. Develop a common health information architecture between VA and DoD facilities that would allow the two-way exchange of health information through the development of modern health information systems.
Developed the ability for the four Level 1 Polytrauma facilities to **access DoD scanned inpatient paper records** and digital radiology images from key OIF/OEF military treatment facilities at Walter Reed and Brooke Army Medical Centers and National Naval Medical Center in Bethesda, Maryland.	Improve quality of care and care coordination between VA and DoD.
DoD began sending VA **electronic Pre-and Post-Deployment Health Assessment and Post-Deployment Health Reassessment** information on separated servicemembers and National Guard and Reserve members who have been deployed and are now demobilized.	Improve access to care for servicemembers, National Guard, and Reserve members, especially for those with possible PTSD.
VA can now **track servicemembers from the battlefield** through Landstuhl, Germany, **to military treatment facilities in America through** a new application, known as the Veterans Tracking Application (VTA). VTA is a Web-based patient tracking and management tool that collects, manages, and reports on patients arriving at military treatment facilities from forward-deployed locations.	Improve access to complete medical records, coordination of care between DoD and VA, and quality of care for servicemembers.

Patient Data Exchange With DoD	
Key FY 2007 Actions	Anticipated Impacts
Developed capability to **share discharge summaries** between VA facilities and ten key military treatment facilities.	Improve quality of care for shared patients (that is, those who receive care from both departments) through the capability to share discharge summaries. Develop a common health information architecture between VA and DoD facilities that would allow the two-way exchange of health information through the development of modern health information systems.

Patient Data Exchange With DoD	
Key FY 2008 Actions	Anticipated Impacts
VA and DoD will begin the **bidirectional sharing of additional viewable electronic health data**, including viewable encounter and clinical notes, procedures, problem lists, history, questionnaires, and forms.	Improve quality of care for shared patients (that is, those who receive care from both departments) through the real-time, two-way view of inpatient and outpatient health data from existing systems at all VA and DoD sites. Develop a common health information architecture between VA and DoD facilities that would allow the two-way exchange of health information through the development of modern health information systems.
VA and DoD will develop a joint plan to define the capability to share **bidirectional digital radiology images** enterprise-wide.	Improve quality of care for shared patients (that is, those who receive care from both departments) through the real-time, two-way view of inpatient and outpatient health data from existing systems at all VA and DoD sites. Develop a common health information architecture between VA and DoD facilities that would allow the two-way exchange of health information through the development of modern health information systems.
VA plans to **integrate the VTA with VA's computerized patient record system (CPRS)** to enable wider visibility of DoD's medical information on patients evacuated from the combat theater.	Improve data sharing and coordination and quality of care. Enhance the seamless transition of active-duty servicemembers to veteran status, as well as making inpatient health-care data on shared patients immediately accessible to both DoD and VA.

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

The two sentinel injuries associated with the OIF/OEF conflict are the blast-induced traumatic brain injury (TBI) caused by explosion shock waves and post-traumatic stress disorder (PTSD). TBI was often hidden from doctors by more obvious injuries before the advent of modern body armor that protects most of a soldier's internal organs, but not the brain. TBI issues include not only the direct physical damage associated with concussive trauma, but many other problems that are only now becoming apparent, such as depression and mental health issues. Secretary Nicholson announced June 11, 2007, that all OIF/OEF veterans seeking treatment at VA are being screened for brain injuries and PTSD.

In a July 2006 report,[1] OIG determined that VHA has enhanced case management for TBI patients, but long-term case management needs further improvement. VA recognizes the need to ensure lifelong care for the veteran and support for his or her family, and is working within the scope of its legal authorities to ensure a network of seamless and effective transition of care for veterans after they leave active duty and after they leave specialized military and VA TBI facilities for local VA or fee-basis facilities near their homes.

According to VA testimony, from the start of OIF/OEF through the first quarter of 2007, a third of discharged service members sought VA care and almost 84,000 or 37 percent of those veterans who sought VA care raised mental health concerns. The most common concerns are PTSD, nondependent abuse of drugs, and depressive disorders. Further evidence of the impact of PTSD on VA is that the number of service-connected disabilities for mental disorders doubled from 2001 to 2005, the last year reported, with mental disorders accounting for more than half of all 100% service-connected disabilities.

Today VHA's nationwide network of facilities provides an array of PTSD treatments ranging from outpatient services at Vet Centers and VA medical centers (VAMC) to full-time hospitalization. While the layman may confuse the specific diagnosis of PTSD with broader mental health issues such as depression, substance abuse, and suicidality that also exist within the returning war veteran population, VA will face in both the short-term and the long-term the challenge of providing effective mental health services to OIF/OEF veterans. Furthermore, because self-injury and substance abuse are not uncommon in veterans with PTSD, OIG has discussed the need for dual-diagnosis treatment programs for returning veterans in several reports.

While we believe that the quality of medical care in VHA facilities is generally excellent, VA is challenged to deliver mental health services and seamless transition of care to veterans who live in areas distant from VA facilities.

[1] The Appendix lists this report, as well as other selected reports pertinent to the five key challenges discussed. The Appendix is not intended to encompass all OIG work in an area.

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

ESTIMATED RESOLUTION TIMEFRAME: FY 2008 AND BEYOND

Focusing on OIF/OEF Veterans	
Key FY 2007 Actions	Anticipated Impacts
Mandated that all **OIF/OEF veteran**s who come to VA for care are **screened for TBI**. If veterans have positive screens, follow-up evaluations are provided by staff with training and expertise in TBI.	Improve quality and coordination of care for veterans with TBI, from mild to severe cases. Improve patient outcomes by implementing early treatment.
Allocated more than $4 million to **enhance staffing** at the **PTSD Clinics** to provide appropriate treatment for veterans with both PTSD and substance abuse problems. Expanded number of **mental health specialists** in Community-based Outpatient Clinics (CBOCs).	Increase access to mental health care and substance abuse services.
Designated a **nurse** or **social worker** to serve as the **OIF/OEF program manager** to coordinate care provided to these veterans at each medical facility and independent outpatient clinic. This position functions as the facility's point of contact for the VA liaisons at the military treatment facilities.	Expedite and facilitate the transfer and care coordination of injured servicemembers to VA medical facilities. Improve communication with family members and care coordinators.
Vet Centers have taken the following actions: o Initiated an aggressive **outreach campaign** to OIF/OEF veterans who return from combat. o **Hired 100 OIF/OEF veteran returnees** to provide outreach services to their fellow combatants.	Meet increased workload associated with the need to provide outreach services and proper case coordination of OIF/OEF veterans. Aid the seamless transition of servicemembers.
Implemented a **seamless transition performance measure** that measures the percentage of severely injured OIF/OEF servicemembers/veterans who are contacted by their assigned VA case manager within 7 calendar days of notification of transfer to the VA system.	Expedite the transfer and care coordination of injured servicemembers to VA medical facilities. Ensure that the injured OIF/OEF servicemember/veteran is properly transferred to the VA system and knows that he/she will be receiving the necessary medical care. Improve support and care coordination for family members.
Established a **Suicide Prevention Hotline.** Suicide Prevention Coordinators have also been designated in all medical centers.	Increase access to care for veterans at risk for suicide and enhance suicide prevention options. Improve VA staff awareness of veteran-related issues and services concerning suicide and suicide prevention.

Focusing on OIF/OEF Veterans	
Key FY 2007 Actions	Anticipated Impacts
Expanded the Polytrauma-TBI System of Care to include 76 facilities across the country, with specially-trained Polytrauma support clinical teams at each site. **Expanded specialty areas**, including military sexual trauma services, suicide prevention initiatives, transitional housing, and psychosocial rehabilitation and recovery.	Provide additional services, including intensive psychological support treatment for both patient and family, and intensive case management. Ensure that polytrauma-TBI patients receive the right level of care at the right type of facility. Allow lifelong coordination of care in the veteran's chosen community.

Focusing on OIF/OEF Veterans	
Key FY 2008 Actions	Anticipated Impacts
VA will assess **whether to increase the number of VA liaisons** stationed at the existing medical treatment facilities to handle the increased volume of OIF/OEF servicemembers/veterans transitioning to VA, and how to address the concerns of the **Army's Warrior in Transition population** at additional military installations.	Maximize staffing resources to meet the volume of care anticipated. Address the concerns of the **Army's Warrior in Transition population** at additional military installations.
VA will establish a **fifth Polytrauma Rehabilitation Center** and enhance services currently available to families and caregivers of veterans with polytrauma and TBI to include delivery of direct medical and mental health care.	Provide additional services, including intensive psychological support treatment for both patient and family, and intensive case management. Allow lifelong coordination of care in the veteran's chosen community.
By the end of FY 2008, VA will increase access to **non-institutional care by 41 percent** and develop programs for areas of greatest need through community-based outreach programs and tele-health services.	Meet the non-institutional care needs of veterans. Provide non-institutional care services to a greater range of eligible veterans.
VA and DoD will **improve bidirectional access to medical records**, by including more data such as vital sign data, family history, social history, other history, and questionnaires/forms available to VA and DoD providers. Discharge summaries, operative reports, inpatient consults and histories, and physicals will also be made available to VA on shared patients at **Landstuhl Regional Medical Center, Germany.**	Provide better health care for shared patients (that is, those who receive care from both departments) through the real-time, two-way view of inpatient and outpatient health data from existing systems at all VA and DoD sites. Develop common health information architecture between VA and DoD facilities that would allow the two-way exchange of health information through the development of modern health information systems.
Increased efforts will be made to devise a long-term solution to **identify high-risk mental health patients in the electronic medical record**, possibly through use of national reminders and flagging of special cases.	Increase effectiveness of identifying high-risk mental health patients and improve access and coordination of care for those patients identified.
The **Veterans Health Education and Information Office** will work with content experts to develop materials for OIF/OEF patients and family members.	Improve awareness of OIF and OEF servicemembers, veterans, and their families on VA health care services.

OIG Challenge #1D: Research

VHA's research component, which has made major advances in medicine in the past half-century, has requested 2008 resources of $1.8 billion. Research, however, poses inherent challenges. Beyond the obvious fiscal accountability issues, VA research must have oversight and boundaries that keep research from harming patients or getting in the way of needed treatment. Congressional hearings and OIG criminal investigations have spotlighted concerns about the suitability of using specific veterans in specific research programs. OIG plans to expand its efforts to ensure that patient safety is not eclipsed by scientific zeal. Areas of continuing OIG concern in recent reports are the credentialing and privileging of research assistants and informed consent by patients.

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

ESTIMATED RESOLUTION TIMEFRAME: FY 2008 AND BEYOND

Strengthening Research Protocols	
Key FY 2007 Actions	Anticipated Impacts
Developed two major handbooks to enhance existing policies on the **protection of human subjects** in research.	Reduce the risk for violations of all applicable regulatory and policy requirements pertaining to human subject research. Ensure that all VHA facilities are fully aware of the laws and policies concerning human subject research conducted or supported by VA and fully compliant with the requirements specified in the Federal Policy (Common Rule) for the Protection of Human Subjects, 56 Federal Register 28001, June 18, 1991, as codified at 38 CFR Part 16. The handbooks are a written commitment by VHA to protect human subjects participating in research.
Required each VA medical facility conducting research to provide appropriate certification of **compliance with regulatory and policy requirements**.	
Published Web site checklists for **human research protections** and **research privacy** to be used by the VA research community.	
Issued guidance to all research offices requiring that **only licensed personnel** with appropriate clinical privileges conduct clinical procedures on research subjects. Also issued a requirement that VA's system-wide credentialing database, VetPro, be used for all health professionals assigned to research, regardless of licensure status.	Allow local research offices and the Research and Development Committees to better track non-licensed personnel and ensure that they are not performing inappropriate or unauthorized procedures on human research subjects.

Strengthening Research Protocols	
Key FY 2008 Actions	Anticipated Impacts
Expand educational programs to include an updated curriculum on human subjects protections, information security, and research compliance.	Reduce the risk for violations of all applicable regulatory and policy requirements pertaining to human subject research. Ensure that all VHA facilities are fully aware of the laws and policies concerning human subject research conducted or supported by VA and fully compliant with the requirements specified in the Federal Policy (Common Rule) for the Protection of Human
Develop additional online training on VA research information privacy and security.	
Ensure that all facilities conducting human subjects research undergo accreditation of their human protection programs.	

Strengthening Research Protocols	
Key FY 2008 Actions	Anticipated Impacts
	Subjects, 56 Federal Register 28001, June 18, 1991, as codified at 38 CFR Part 16.
Issue additional regulatory guidance on financial conflict of interest in VA research.	Reduce the risk for violations of financial conflict in VA research. Ensure that all VHA facilities are fully aware of and compliant with the laws and policies concerning financial conflict of interest in VA research.

OIG Challenge #2: BENEFITS PROCESSING

-Strategic Overview-

VA faces an increasing disability claims workload from returning OIF/OEF veterans, reopened claims from veterans with chronic progressive conditions, and additional claims from an aging veteran population. New laws have expanded benefits eligibility, encouraging more veterans to apply for assistance, a trend which is ongoing in wartime. These factors will continue to present VA with major challenges in timely and accurate processing of disability claims for monetary benefits. In addition, due to factors such as the increasing complexity of the claims veterans file, the complicated rules that the Veterans Benefits Administration (VBA) must follow in deciding disability claims, and the loss of seasoned claims processing staff, VA will face continuing challenges in the accuracy and consistency of benefits decisions.

The President's 2008 budget request for the VA includes $45.3 billion for entitlement costs, which includes monetary benefits for 3.2 million recipients of compensation benefits. VBA estimates receiving 800,000 disability claims again in 2008, which, in the face of estimated pending balances of about 400,000 rating and almost 180,000 non-rating claims, present serious program management challenges. Benefits claims—including appeals and lawsuits involving denied claims—are increasing while VBA staffing remains near pre-Iraq war levels.
OIG audits and investigations identify actions VBA can take to improve the timeliness and quality of claims processed, minimize its exposure to fraud, and reduce the amount of improper payments.

OIG CHALLENGE #2A: Pending Claims and Estimated Receipts

Large inventories of pending claims for compensation and pension (C&P) benefits have been a problem for many years, and they continue to be the focus of congressional hearings and press accounts. VBA has said making headway is proving difficult because veterans are filing new and reopened claims faster than VBA generates decisions on pending claims. In 2006, VA received 806,382 claims, and expects 811,000 in 2007. VBA's internal difficulties in handling the workload—compounded by the loss of experienced rating personnel—are further aggravated by differences between DoD and VA disability rating rules and systems. This is one of the areas addressed in recommendations by the Task Force on Returning Global War on Terror Heroes, and under review by the Veterans' Disability Benefits Commission, established by the National Defense Authorization Act for 2004, and which issued its report and recommendations on October 3, 2007. For example, examinations performed by DoD for purposes of determining fitness for continued service are generally not adequate for application of the VA Schedule of Rating Disabilities in determining, for VA disability compensation purposes, the average

impairment in earning capacity. Unless a service member is participating in the Benefits Delivery at Discharge program, VA must wait until he or she is discharged and files a claim before obtaining service medical records, including any medical or physical board proceedings, prior to determining if additional examinations are needed. This contributes to the lengthy claims process faced by veterans.

VA's Program Response to OIG Challenge #2A: Pending Claims and Estimated Receipts

ESTIMATED RESOLUTION TIMEFRAME: FY 2008

Improving Claims Processing Business Operations	
Key FY 2007 Actions	Anticipated Impacts
Increased **overtime** funding for claims processing staff. **Added** approximately 1,000 claims processing FTE. Used 50 **rehired annuitants** to provide training and mentorship and to assist the **Tiger Team** with claims processing.	Increase the number of completed rating-related claims.
Increased the minimum RVSR **national production requirement** to 3.5 weighted actions per day.	
Increased **training initiatives** to improve technical and management abilities for **new managers**.	Improve technical and managerial skills for new managers.
Began **consolidation of death pension claims processing** to the three VBA Pension Maintenance Centers (PMCs).	Improve efficiency and effectiveness in processing disability rating claims.

Improving Claims Processing Business Operations	
Key FY 2008 Actions	Anticipated Impacts
Implement two initiatives designed to increase the productivity of new hires. o Modify the Veteran Service Representative (VSR) training protocols to immediately **focus new hires on processing burial and dependency claims** to allow them to become productive very quickly. o Hire new VSRs at the three PMCs and continue the **consolidation of death pension claims** to the PMCs. The consolidation is expected to be completed by late FY 2008 or early FY 2009.	Free other more experienced regional office staff for assignment to disability claims processing. Improve efficiency and effectiveness in processing disability rating claims.
Consolidate original disability pension claims processing to the three PMCs and evaluate consolidation of dependency and indemnity compensation claims processing.	Improve efficiency and effectiveness in processing disability rating claims.
Conduct a joint VA and Department of Defense **Disability Evaluation System pilot**.	Improve the interaction and data sharing between VA and DoD and services to separating servicemembers with disabilities.

OIG CHALLENGE #2B: Appeals

The growing number of veterans' claims for disability benefits entering the appellate processes also contributes to the challenge VA faces and draws attention to timeliness from all stakeholders, including service organizations, Congress, and the media.

The appeal rate on disability determinations has increased since 2000 more than 50 percent, from approximately 7 percent to 11 percent. Over 130,000 appeals are currently pending in VA regional offices and VBA's Appeals Management Center, including cases requiring processing prior to transfer to the Board of Veterans' Appeals (BVA) and cases remanded to VBA offices by BVA or the U.S. Court of Appeals for Veterans Claims (CAVC) following an appeal. There are over 30,000 additional appeals now pending at BVA.

The chief judge of CAVC testified before a House Committee on Veterans' Affairs subcommittee on May 22, 2007, that the Court is facing its highest caseload ever, averaging 300 appeals per month, a figure that does not yet include appeals by OIF/OEF veterans. In the first half of 2007, CAVC received 2,542 new appeals, compared to 3,729 for all of 2006. The judge attributed this in part to the sharp increase in denial of claims by BVA, which virtually doubled in a 2-year span, going from 9,299 in 2004 to 18,107 in 2006. All of these processes—initial decisions by VBA, pre-appellate reviews in VA regional offices, actions by VBA's Appeals Management Center, consideration at BVA, and ultimately consideration by CAVC—present VA with a formidable challenge in terms of timeliness in providing monetary benefits to veterans.

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

ESTIMATED RESOLUTION TIMEFRAME: FY 2009

Improving Claims Processing Business Operations	
Key FY 2007 Actions	Anticipated Impacts
As a result of joint VBA/BVA training on reducing avoidable remands, **reduced the remand rate** from 56.8% in 2004 to 35.7% by mid-year 2007	Increase the number of appeals decided, and reduce the number of pending appeals.
Used **overtime** for writing and dispatching decisions.	
Used **mentoring and training** on efficient case review and decision writing with an emphasis on writing clear, concise, coherent, and correct decisions.	Increase the quality of decisions, and increase the number of appeals decided.
Expanded the **flexi-place program** to include 88 high-achieving attorneys who have committed to an increased production goal of 170 cases per year.	Increase the number of appeals decided.
Began evaluating the possible consolidation of **appellate workload** and added additional FTE to address appellate workload.	

Improving Claims Processing Business Operations	
Key FY 2008 Actions	Anticipated Impacts
Continue using strategies described above for 2007.	Increase the number of appeals decided, reduce the number of pending appeals, and increase the quality of decisions.

OIG CHALLENGE #2C: Accuracy and Variance

VBA's long-term efforts to improve the quality—the accuracy and consistency—of claims decisions have resulted in some improvements. VBA conducts accuracy reviews through its Systematic Technical Accuracy Review (STAR) program. In 2005, VBA assigned 18 employees, who reviewed 15,200 cases. The rating and authorization reviews focus on benefit entitlement decisions, and on filed documentation and notice to claimants. One element of STAR determines if the decision was correct, while the other ensures file documentation supports the decision and that proper notice occurred. In a joint hearing on April 12, 2007, before the Senate Committee on Veterans' Affairs and the Senate Committee on Armed Services, the Under Secretary for Benefits stated efforts to address this challenge include "an aggressive and comprehensive program of quality assurance and oversight to assess compliance with VBA claims processing policy and procedures and assure consistent application." He stated that STAR trending of the rating decision quality has resulted in an increase in accuracy over the last 4 years from 81 percent to 89 percent. However, this means that 1 decision in 10 is still inaccurate by VBA's own measure.

A 2005 OIG report on variances in VA disability compensation payments concluded that some veterans' disabilities are more susceptible than others are to variations in ratings. This is due in part to the fact that some diagnostic conditions, such as PTSD, lend themselves to more subjective decision-making practices and that some result from using a disability rating schedule based on a 60-year-old model. In confirming OIG concerns about variance, the National Academy of Sciences study, *A 21st Century System for Evaluating Veterans for Disability Benefits (2007),* conducted under contract with VA, concluded that STAR sampling does not address accuracy at the body system or diagnostic code level, and it does not measure consistency across regional offices. Furthermore, we understand the Rating Schedule under study by the Veterans' Disability Benefits Commission will address a number of concerns coming from use of VA's rating schedule. In recognition of the OIG-identified challenge, VBA has begun taking steps to address the controllable variation. According to the April 12, 2007, testimony of the Under Secretary for Benefits, in addition to the STAR program, VBA's Compensation and Pension Service is identifying unusual patterns of variance in claims adjudication by diagnostic code and VBA is conducting site surveys of regional offices to measure compliance, with particular emphasis on current consistency issues. VA also has received a contract study on removing, to the extent possible, variance in disability decisions across regional offices.

VA's Program Response to OIG Challenge #2C: Accuracy and Variance

ESTIMATED RESOLUTION TIMEFRAME: FY 2008

Improving Quality, Accuracy, and Consistency of Claims Processing	
Key FY 2007 Actions	Anticipated Impacts
Conducted a pilot project to monitor **consistency of decision-making** for rating-related claims. Conducted a consistency review focusing on grants and evaluations of **post-traumatic stress disorder (PTSD) claims** from a regional office identified during the pilot as a statistical outlier.	Allow for better management of the compensation and pension programs' accuracy, timeliness, and consistency of decision-making for rating-related claims.
Developed a plan to reorganize and expand the STAR staff to enable **increased** regional office accuracy review **sampling**, expanded **rating data analysis**, and focused disability decision consistency reviews. STAR reviewers conducted approximately 15,385 reviews in 2007, compared to 13,696 reviews in 2006**.**	

Improving Quality, Accuracy, and Consistency of Claims Processing	
Key FY 2008 Actions	Anticipated Impacts
Begin routine quarterly monitoring of compensation and pension rating decisions by diagnostic code.	Allow for better management of the compensation and pension programs' accuracy, timeliness, and consistency of decision-making for rating-related claims.
Expand the STAR staff to accomplish additional reviews.	
Complete the pilot project mentioned above by conducting **consistency reviews** focused on **individual unemployability** (IU) decisions from a regional office identified as a statistical outlier.	Use results from the pilot project to identify unusual patterns of variance in claims decisions and incorporate focused case reviews into routine quality oversight by STAR.

OIG Challenge #3: FINANCIAL MANAGEMENT

-Strategic Overview-

Sound financial management is not only the stewardship that makes the best use of limited public resources, but also the ability to collect, analyze, and report reliable data on which resource use and allocation decisions depend. OIG oversight assists VA in providing its program managers with accurate, reliable, and timely information for sound oversight and decision making, while identifying opportunities to improve the quality, management, and efficiency of VA's financial management systems.

Although VA has received unqualified ("clean") opinions in the annual consolidated financial statements (CFS) audits since 1999, these audits continue to report the lack of an integrated financial management system, financial operations oversight, and IT security controls as material weaknesses. This report discusses IT security controls in the next section.

OIG CHALLENGE #3A: Lack of an Integrated Financial Management System

While VA has addressed some OIG concerns, including the corrective action in 2005 to eliminate the judgments and claims reportable condition identified in the 2004 audit, the CFS audits continue to report the lack of an integrated financial management system as a material weakness. This is an area of VA noncompliance with the *Federal Financial Management Improvement Act of 199*6 (FFMIA), Public Law 104-208. It increases the risk of materially misstating financial information.

The 2005-2006 CFS audit noted, for example, that reconciliations of property records in the loan guaranty programs continued to identify significant differences from non-interfaced systems. Because a number of C&P and education programs did not directly interface with the general ledger or do so at various intervals, numerous adjusting entries had to be made to reconcile balances and ensure that amounts are properly stated. In the life insurance programs, the lack of system interface with VA's general ledger created a need for a significant number of adjusting entries, with the result that some were not posted to the general ledger, nor were reconciling items identified and posted timely.

VA's 4-year remediation program to address this material weakness—the Financial and Logistics Integrated Technology Enterprise (FLITE)—aims to correct financial and logistics deficiencies throughout the Department. FLITE is the successor to the VA's failed CoreFLS program, which was halted after VA had spent $342 million on it. However, in its report to the Committee on the Budget, the House Committee on Veterans' Affairs recommended decreases in funding for FLITE, commenting, "there is much the VA must accomplish first before it should be spending $35 million on this program."

VA's Program Response to OIG Challenge #3A: Lack of an Integrated Financial Management System[2]

ESTIMATED RESOLUTION TIMEFRAME: FY 2012

[2] The responsibility for remediating this major management challenge is a joint effort of VA's Chief Information Officer and Chief Financial Officer.

Steps toward an Integrated Financial Management System	
Key FY 2007 Actions	Anticipated Impacts
As part of the **Financial Reporting Data Warehouse (FRDW)** efforts, VA did the following: • Put into production the PAID (Payroll system) to Financial Management System (FMS) interface. • Put into production the Loan Guarantee – Loan Service & Claims (LS&C) interface.	Simplified reconciliation between program system interfaces (PAID, LS&C) and FMS, as well as providing an audit trail. FRDW is being implemented to remediate a portion of the Lack of an Integrated Financial Management System (LIFMS) material weakness.

Steps toward an Integrated Financial Management System	
Key FY 2007 Actions	Anticipated Impacts
As part of the FLITE efforts, VA did the following: • Established and implemented the FLITE governance framework. • Developed the FLITE Program baseline cost estimates. • Developed a **high-level master plan** for integrating logistics and financial programs under the FLITE Program Office. • Conducted a **FLITE Stakeholder Analysis and Communications Needs Assessment** and developed the Organizational Change Management Strategy. • Developed **functional logistical and financial requirements** and business processes documents. • Determined the COTS solution for the Strategic Asset Management (SAM) component of the program. • Conducted a technical evaluation of financial software. • Awarded a contract to complete the Integrated Financial Accounting System (IFAS) financial requirements and business processes. • Developed a FLITE Acquisition Strategy. • Performed a full analysis on lessons learned from CoreFLS to monitor during the FLITE program lifecycle.	Sound FLITE Program plans, SAM and IFAS requirements documents, technical evaluation, and contract support for change management activities supported by all stakeholders will ensure success of the FLITE program, which will remediate LIFMS.

Steps toward an Integrated Financial Management System	
Key FY 2008 Actions	Anticipated Impacts
FRDW-related work resulted in the establishment of **three key system interfaces**: • Loan Guarantee – Centralized Property Tracking System to FMS interface. • VistA Accounts Receivable, Loan Guarantee – Countrywide Home Loans, and Loan Guarantee – Funding Fee Payment System interface. • Fee Program, Veterans Education Benefits, and Vocational Rehabilitation interface.	Simplified reconciliation between program system interfaces (PAID, LS&C) and FMS, as well as providing an audit trail. FRDW is being implemented to remediate a portion of the Lack of an Integrated Financial Management System (LIFMS) material weakness.
FLITE-related work will consist of the following: • Initiate request for proposal (RFP) and award the SAM Implementation contract. • Initiate SAM pilot at Milwaukee VA Medical Center to attain initial operating capability of the SAM system. • Initiate RFP and award the IFAS component of FLITE following OMB financial management line of business (FMLoB) guidance. • Take steps to initiate IFAS pilot. • Continue change management and communication activities targeted to VA stakeholders.	FLITE program success will result in establishing a fully integrated financial management system for VA.

OIG CHALLENGE #3B: Operational Oversight

The CFS audits also found a material weakness in VA's operational oversight over accounting and financial reporting. Key internal controls and reconciliation processes were performed inconsistently and incompletely, sometimes failing to assure appropriate management review. This caused a variety of problems. Extended amounts of time were required to obtain requested details of transactions for audit testing. Support for certain note disclosures were difficult to obtain, and unreconciled differences continued to exist at year's end for tort claims. Auditors also found no evidence that certain non-Medical Care Collections Fund receivables reconciliations were being performed or completed in a timely manner—medical centers stated they did not have the staff to perform all the reconciliations. Delinquent receivables were not consistently followed up for collection.

Combined with the lack of an integrated financial management system, noted above, these weaknesses complicate VA's ability to prepare and report financial statements on time, impairing its ability to meet its deadline. Financial statements were provided late and required a number of iterations before completion of the audit. A significant number of adjustments needed to be proposed by the auditor. Many of the problems found by the audit process should have been discovered by management through routine operational oversight.

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

ESTIMATED RESOLUTION TIMEFRAME: FY 2009

Operational Oversight	
Key FY 2007 Actions	Anticipated Impacts
Completed full implementation of a **financial management reporting system** to produce the annual as well as quarterly financial statements. Enhanced the system to produce a majority of required **footnote disclosures** accompanying the financial statements, ensuring **consistency of data** between the principle statements and footnotes as well as significantly improving the timeframe needed to generate the statements.	Improved timeliness and accuracy of financial statements preparation and reporting, including footnotes. Staff will shift focus to analysis and review of financial data and statements, as extensive manual efforts will no longer be required.
Implemented key components of **remediation plans** related to findings in the cash management and financial reporting key business process reviewed under OMB Circular A-123, Appendix A.	These actions will strengthen the system of internal controls, thereby further mitigating fraud, waste, abuse, or mismanagement and improve the accuracy of VA financial reports.
Initiated a multi-year project, the **Financial Policy Improvement Initiative (FPII)**, to update all financial policies and procedures.	Departmentwide standardization of financial management policies and procedures to ensure they are uniform, consistent, and accurate, as well as comply with, and reference where appropriate, all financial management laws and regulations. The "new" financial policies and procedures will ensure key internal controls and reconciliation processes are performed consistently and completely, as well as ensure appropriate management review of the detail and support for the financial statements. New VA financial policy will be drafted where none exists or is outdated, ensuring it complies with FASAB standards, financial management laws and regulations, and OMB and Treasury financial management guidance.
Increased oversight of **field compliance** with the Department's policies and procedures by adding additional audit steps related to findings in the CFS audits to field reviews conducted by VA's Office of Business Oversight (OBO).	The additional audit steps will report on field compliance with issues identified as a lack of operational oversight in a broader range of VHA facilities. The broader scope will assist VHA managers in identifying and ultimately correcting the non-compliance issues at the facility level.
The VHA Chief Business Office worked closely with the Chief Financial Officer (CFO), the Office of Compliance and Business Integrity, and Health Information Management to develop strategies to assist medical center staff in understanding guidance and to provide training related to the **Medical Care Collections Fund (MCCF) accounts receivable** follow-up procedures for the medical center staff.	Improved accuracy and timeliness in collection, reconciliation, and follow-up of accounts receivables.

Operational Oversight	
Key FY 2008 Actions	Anticipated Impacts
Implement an Intragovernmental reporting and **reconciliation system** to improve the quality and consistency of reporting.	Improved quality of VA data reported in the Governmentwide Financial Report.
Continue FPII to update all **financial policies** and **procedures**.	Departmentwide standardization of financial management policies and procedures to ensure they are uniform, consistent, and accurate, as well as comply with, and reference where appropriate, all financial management laws and regulations. The "new" financial policies and procedures will ensure key internal controls and reconciliation processes are performed consistently and completely, as well as ensure appropriate management review of the detail and support for the financial statements. New VA financial policy will be drafted where none exists or is outdated, ensuring it complies with FASAB standards, financial management laws and regulations, and OMB and Treasury financial management guidance.
Continue increased oversight of **field compliance** with the Department's policies and procedures.	The additional audit steps will ensure field compliance with issues identified as a lack of operational oversight in a broader range of VHA facilities. The broader scope will assist VHA managers in identifying and ultimately correcting the non-compliance issues at the facility level.
Complete **OMB Circular A-123, Appendix A**, review of key business processes and develop remediation processes and plans to correct findings.	An assessment of the internal controls over financial reporting for all key business processes will be performed. Internal control weaknesses will be identified and remediation plans to correct the deficiencies will be developed. Remediation actions will have been completed or begun and an ongoing monitoring and verification program will be implemented.
Provide additional updated guidance and continued training to medical center staff.	Consistent implementation and adherence to established VA and VHA policies.
Implement a **quality improvement program** to address the needs to share better practices among all facilities and establish a quality improvement entity to ensure field implementation of better practices.	
Continue site assist visits for the lower performing sites.	

OIG Challenge #4: PROCUREMENT PRACTICES

-Strategic Overview-

Procurement is the acquisition of goods and services needed to meet VA's mission. VA must maintain a procurement program that can provide quality products, services, and expertise that must be delivered in a timely fashion, for a reasonable price, and to the right place. VA spends over $6 billion each year purchasing pharmaceuticals, medical/surgical supplies and equipment, and health care services needed to provide quality health care to veterans. VA also purchases goods and services needed to maintain its IT infrastructure and to conduct studies to improve programs and operations.

OIG has three critical roles in evaluating VA's procurement programs and operations: oversight of procurement practices both at Central Office and in the field to ensure compliance with applicable laws and regulations, investigations to detect and prevent illegal activity, and conducting preaward and postaward reviews of VA's Federal Supply Schedule (FSS) contracts and contracts for health care resources awarded by VA medical facilities.

Since 2001, OIG audits, investigations, and reviews have identified significant and persistent deficiencies in the planning, solicitation/award, and administration of contracts throughout VA that have resulted in the loss of hundreds of millions of dollars. Preaward and postaward reviews of FSS and health care resource contracts have resulted in the recovery of $130 million and the identification of potential cost savings of $2 billion, of which over $1.4 billion was realized. Criminal investigations also have identified violations of law involving fraud, bribery, and theft in VA's procurement programs. The lack of oversight, particularly in purchases made using the Government credit card, makes VA's procurement programs vulnerable for illegal activity.

OIG CHALLENGE #4A: Procurement Failures

VA's most costly procurement failures involved the development and implementation of IT systems intended to provide better visibility and oversight of VA's programs and operations, including its financial activities. These include the failure of CoreFLS, a system that was intended to capture and monitor how VA spends its resources. OIG's 2004 review of the failed deployment of CoreFLS found inadequacies with the planning, award, and administration of the contract. These inadequacies and the failure by VHA to implement the legacy systems needed to integrate the software led to the project's failure and the loss of over $200 million. As noted in a 2007 review, similar problems led to the failure of a contract to upgrade VA's Patient Financial Services System and the loss of $30 million. Inadequate planning and poor contract administration resulted in the demise of a Central Incident Response Capability contract which left VA's IT infrastructure vulnerable. The contract, which was valued at $102.7 million over a 10-year period, was allowed to expire after 2½ years due to lack of funding. Changes to the contract and the lack of internal controls and oversight resulted in the expenditure of $91.8 million (89.4 percent of the total value) in the 2 ½ year time period.

Poor procurement practices are not limited to Central Office contracts or IT contracts. OIG audits and reviews have consistently identified procurement deficiencies in VHA medical facilities. A recent audit of financial irregularities at the VA Boston Health Care System identified significant violations of procurement and financial laws and regulations that would have gone undetected but for a complaint to the OIG Hotline. A 2005 OIG report identified problems in the award and administration of sole-source contracts with affiliated institutions to purchase health care

resources. Although VA concurred with the report and issued a nationwide directive to implement the recommendations, subsequent reviews show that the problems persist and there is a lack of compliance with the Directive.

VA's Program Response to OIG Challenge #4A: Procurement Failures

ESTIMATED RESOLUTION TIMEFRAME: FY 2009

Procurement Failures	
Key FY 2007 Actions	Anticipated Impacts
Began to use Integrated Product Teams (IPTs) and Contract Review Boards (CRBs) for VA acquisitions over $5 million. VA attorneys served on CRBs to **provide guidance on potential terminations of contracts**.	This approach leads to better defined and more useful requirements definitions.
Began to develop the **Contract Administration Program** for VA acquisitions estimated to exceed $5 million.	Implemented to improve contract administration, with contracting and program offices working together to manage contracts throughout their life cycle.
Provided oversight of **field compliance** with federal and Departmental acquisition policies and procedures, including three VISN-wide contract inspections.	Oversight programs, such as contract inspections, identify areas of non-compliance with rules and regulations as well as recommendations for corrective actions. The information allows managers at both the field station level and VA Central Office to correct deficiencies in internal controls to prevent future recurrence of non-compliance. Provides local management with recommendations to improve their acquisition activities.
Engaged an independent third party to conduct a **cost-benefit analysis** to recommend a strategy for replacement of the current Veterans Health Information Systems and Technology Architecture (VistA) **billing and accounts receivable system**.	Improve the oversight and internal controls of the Contract Administration Program within the Department.

Procurement Failures	
Key FY 2008 Actions	Anticipated Impacts
Expand IPTs and CRBs for VA acquisitions over $5 million.	Will continue to improve the acquisition process and improve requirements definitions.
Fully implement the Contract Administration Program for VA acquisitions estimated to exceed $5 million.	Will continue to manage and improve the contract administration process.
Hire VA **contract attorneys** to be strategically placed in VHA networks.	
Continue oversight of field compliance with federal and Departmental acquisition policies and procedures by conducting at least **one VISN-wide contract inspection**.	Oversight programs, such as contract inspections, identify areas of non-compliance with rules and regulations as well as recommendations for corrective actions. The information allows managers at both the field station level and VA Central Office to correct deficiencies in internal

Procurement Failures	
Key FY 2008 Actions	Anticipated Impacts
	controls to prevent future recurrence of non-compliance. Will continue to conduct reviews and provide local management with recommendations to improve their acquisition activities.
Develop a comprehensive **education training** program for **Enhanced Medical Sharing Contracts**.	Improve the oversight and internal controls of the Contract Administration Program within the Department.
Begin **random audits of IT contracts** greater than $1 million to ensure compliance with applicable directives.	Enable VA to identify any deviations from directives and policy, insufficient acquisition planning, and inadequate contract administration. Identification of these issues and subsequent analysis would enable VA to develop and implement processes that ensure early access to acquisition staff for improved acquisition planning and rigorous contract administration to ensure that review and proper payment of vendor invoices and modifications remain within scope. Help VA identify areas where increased or improved training for contracting and project management staff would improve the planning, implementation, and administration of contracts.

OIG CHALLENGE #4B: Lack of Corporate Knowledge

At the present time, VA has no corporate database identifying contracts that have been awarded, individual purchase orders, credit card purchases, or the amount of money spent on goods and services. Lacking a corporate database, the Department does not know what is purchased, from whom, whether purchases are through a contract or open market, or whether prices paid are fair and reasonable. As just one example, VA spends billions of dollars annually using purchase cards with little oversight because the relevant information is maintained only in databases at each facility. Because the procurement program is decentralized and there is no corporate database or effective internal controls, including an oversight program, VA cannot provide assurance that the taxpayer dollars have been spent effectively and without waste.

VA recently implemented a nationwide program, eCMS, to capture contracting actions at both Central Office and in the field. The effectiveness of this program will depend on whether VA contracting entities comply with the policy and whether the data entered into the system is accurate and complete. Although compliance will provide VA with more information regarding the number and type of contracts awarded, it will not provide sufficient information regarding compliance with procurement laws and regulations, whether the contracts were necessary or in the best interest of the Government, and, more importantly, it will not capture individual purchases. In addition to developing information systems needed to capture procurement data, VA also must develop metrics as well as standards to monitor and measure acquisition workload, performance, and purchasing throughout the Department.

There is a clear need to improve the quality and timeliness of legal, technical, and other reviews to guarantee that all contracts are in the best interest of the Government and can withstand legal challenge.

VA's Program Response to OIG Challenge #4B: Lack of Corporate Knowledge

ESTIMATED RESOLUTION TIMEFRAME: FY 2009

Lack of Corporate Knowledge	
Key FY 2007 Actions	Anticipated Impacts
Began to implement the **Electronic Contract Management System (eCMS)** throughout VA and use it to facilitate Federal Procurement Data System (FPDS) reporting and generation of management reports.	Mandated for all procurement actions estimated over $25,000. Existing contracts will now be recorded into eCMS, and any resultant actions throughout the contract life cycle will be processed in eCMS.
Initiated Federal Acquisition Certification-Contracting (FAC-C) **certification of VA acquisition workforce**.	Implemented to bring VA's acquisition workforce into compliance with Federal Acquisition Regulation 1.602-1(a).
Exercised acquisition oversight over field acquisition activities through contract inspections and acquisition audits. Conducted **quarterly data mining of VA purchase card activity** to detect and report violations of federal and Departmental policies and procedures.	Oversight programs, such as contract inspections and purchase card data mining, identify areas of non-compliance with rules and regulations as well as recommendations for corrective actions. The information allows managers at both the field station level and VA Central Office to correct deficiencies in internal controls to prevent future recurrence of non-compliance.
Developed and implemented the Contracting Officer Technical Representative (COTR) Web-based training program.	Improve and promote continuing education of VA COTRs.

Lack of Corporate Knowledge	
Key FY 2008 Actions	Anticipated Impacts
Publish the VA Acquisition Regulation (VAAR) as a final rule in the Federal Register.	It is expected that issuance of the VAAR rewrite will lead to more proactive acquisition planning, well-drafted contracts, and effective contract administration.
Complete the initial phase of certifying the VA acquisition workforce.	Satisfy VA's compliance with federal regulations.
Evaluate the acquisition system and organizational structure.	Improve the oversight and internal controls of the Contract Administration Program within the Department.
Conduct a spend analysis of VA expenditures.	
Continue program improvements of eCMS.	Continue to record and track contracts throughout their life cycle.
Implement and monitor the use of **procurement** and **contracting standard operating procedures**.	Improve the oversight and internal controls of the Contract Administration Program within the Department.

OIG Challenge #5: INFORMATION MANAGEMENT

-Strategic Overview-

The multimillion-dollar failure of VA's CoreFLS system development underscored the challenge of effective IT governance—an organizational structure with well-defined roles and responsibilities to ensure that IT investments cost-effectively support the Department's mission and mitigate the risks associated with IT. For the past several years, OIG reports have repeatedly recommended that VA pursue a more centralized IT governance approach, applying appropriate resources and establishing a clear chain of command and accountability structure to implement and enforce IT internal controls. VA has moved to consolidate IT resources and authority under the Department's CIO, transferring employees from VA administrations to the direct control of the Assistant Secretary. This integration, in which the CIO will be in charge of all VA information technology development and operations, will take several months to complete.

VA has made greater progress in IT governance than in IT security, but until the Department succeeds at IT governance, it will continue to have problems with IT security. The January 2007 Birmingham data loss, VA's second major failure of this scope in a year, demonstrates the point. Information systems within VA must be adequately managed and protected to ensure information availability, integrity, authentication, and confidentiality. These systems must also be cost-effective and used in a lawful and ethical manner, while meeting the needs of the user. OIG work will help assess VA efforts to address information security control weaknesses and to establish a comprehensive integrated security management program.

OIG CHALLENGE #5A: Confusion of Rules and Guidance

Numerous separate pre-consolidation IT policies and guidance are still in effect in VA's various administrations and offices. There has also been an understandable rush to issue new directives and training requirements. The result is that most VA employees find themselves in a morass of highly-detailed and yet often unclear directives, memoranda, and training and certification mandates. This tangle has commendably raised awareness of IT security issues, but has not resulted in better information handling. It also concerns OIG that much of VA's monitoring and remediation efforts since opening the National Security Operations Center in August 2006 involve relatively minor breaches in e-mails among VA employees, rather than focusing on large unencrypted data sets at rest, which present the greatest risks.

Furthermore, these policies have created confusion as to what is required, and in some cases failed to provide technical tools to protect information. The initial 2007 draft of a VA handbook on IT security, for example, was approximately 300 single-spaced pages that was expected to be widely read. It was prepared to address OIG's recommendation for a single comprehensive policy, but instead was a single unwieldy and confusing handbook. VA is making real progress at improving its IT governance and security, but it needs to resist the temptation to paper over real problems. The focus for making IT security policy work must be making it understandable to the employees who must use it.

VA's Program Response to OIG Challenge #5A: Confusion of Rules and Guidance

ESTIMATED RESOLUTION TIMEFRAME: FY 2009

Confusion of Rules and Guidance	
Key FY 2007 Actions	Anticipated Impacts
Required all new employees to sign a **statement of commitment and understanding** regarding their responsibilities for protecting sensitive and confidential VA information.	Ensure that employees understand not only their obligations and responsibilities for protecting VA sensitive information but also the penalties for non-compliance.
Issued numerous IT memorandums, directives, and policies addressing several high-risk areas involving the **use of sensitive information**.	Strengthen controls over the protection of VA sensitive information.
Updated and improved **VA Cyber Security and Privacy Awareness** training modules.	Increase user awareness of the requirements associated with information security and the protection of VA sensitive information.
Issued procedures for reporting and handling of **computer security incidents**.	Improve the Department's capability to quickly and effectively respond to IT security incidents, which will help ensure the confidentiality, integrity, and availability of VA sensitive information.
Established an **Incident Resolution Core Team** consisting of key management officials including the Chief Information Officer, Chief Technology Officer, Privacy Officer, and other senior officials from VA's Offices of Information Technology, General Counsel, Cyber Security, Congressional Relations, Public Affairs, and Human Resources.	
Deployed Rights Management Services (RMS) software to handle email encryption as well as **file and document encryption for data at rest.**	Better safeguard sensitive data within VA through encryption and controlling what authorized recipients can do with sensitive data.
Encrypted over 18,000 VA laptops out of a total of 26,700 laptops.	Help ensure the confidentiality, integrity, and availability of VA data by providing stronger controls over the data stored on mobile computing devices.

Confusion of Rules and Guidance	
Key FY 2008 Actions	Anticipated Impacts
All new employees will sign a **statement of commitment and understanding** regarding their responsibilities for protecting sensitive and confidential VA information.	Ensure that all new employees understand not only their obligations and responsibilities for protecting VA sensitive information but also the penalties for non-compliance.
Deploy **tape encryption** throughout VA. This is for backup tapes that are carried off-site, in an effort to **encrypt large data sets at rest**.	Help ensure the confidentiality, integrity, and availability of VA sensitive data by providing stronger controls over the transmission, processing, and/or storage of sensitive data.
Complete the roll-out of **port security and host integration software** to secure large data sets.	
Develop plans to integrate evolving technology and other best practices into the **encryption management program**.	

OIG CHALLENGE #5B: Material Weakness in IT Security Controls

For several years, OIG reports have also identified serious weaknesses in IT security controls—controls to protect the integrity of VA data and guarantee the privacy of veterans and their families. OIG's annual CFS audits, for example, continue to report IT security controls as a material weakness. Although the 2006 and 2005 CFS audit noted that management of data centers and several program offices have taken actions to remediate previously reported elements of IT control weaknesses, VA program and financial data continue to be at risk due to serious weaknesses related to lack of effective implementation and enforcement of agency-wide security programs in a coordinated manner. The audit found that these weaknesses placed sensitive information, including financial data and veterans' medical and benefit information, at risk of misuse, improper disclosure, theft, or destruction, possibly occurring without detection. The audit's assessment of the general and application controls of VA's key financial systems identified significant areas of control weaknesses. Since this audit was conducted, VA has begun the integration of the Austin, Hines, and Philadelphia data centers into its Corporate Franchise Data Center.

VA's Program Response to OIG Challenge #5B: Material Weakness in IT Security Controls

ESTIMATED RESOLUTION TIMEFRAME: FY 2010

Material Weakness in IT Security Controls	
Key FY 2007 Actions	Anticipated Impacts
Began to implement the Data Security, Assessment and Strengthening of Controls Program (DS-ASC) to **centrally manage** implementation, enforcement, and **remediation of IT security controls** throughout the Department.	Consistent and more effective management and remediation of IT security deficiencies.
Established the Office of IT Oversight & Compliance, which consolidated existing IT security inspection/compliance program activities into one office to assist the CIO in **centralized enforcement of VA IT security controls.**	Improve ways to monitor and enforce compliance with existing laws and regulations regarding IT security.

Material Weakness in IT Security Controls	
Key FY 2008 Actions	Anticipated Impacts
Certify and accredit over **600 Department information systems**.	Allow officials to better understand and manage the risks associated with the operation of VA information systems.
Centralize enforcement and **remediate IT security deficiencies** via the DS-ASC.	More effective and timely remediation of IT security deficiencies.
Inspect IT controls at VA facilities.	Improve IT security controls.

OIG CHALLENGE #5C: VA Information Security Program Reviews

For the past several years, OIG has reported vulnerabilities with IT security controls in our CFS audit reports; *Federal Information Security Management Act* (FISMA), Public Law 107-347, reports; and CAP reviews. Each year, OIG continues to identify repeat deficiencies and repeat recommendations that remain unimplemented. All five FISMA reviews have found major problems that have never been corrected and made recommendations that have never been implemented. OIG's 2004 FISMA Audit reported that inadequate IT security controls for VA's financial management systems continued to place VA program and financial information at risk. The audit found inadequate implementation and enforcement of access controls to financial management systems and data, improper segregation of duties for the staff that operate and maintain key IT systems, inadequate continuity planning for IT services, and inconsistent development and implementation of system change controls. OIG's 2005 FISMA Audit reaffirmed all the unimplemented recommendations, and added another VA action, but two of the older recommendations were subsequently closed as being implemented. The 2006 FISMA Audit added additional recommendations in September 2007. OIG has reported IT security as a major management challenge for the Department each year for the past 6 years.

OIG's 2006 review of circumstances surrounding the theft of a personally-owned laptop computer and external hard drive containing personal information on veterans and military personnel also recommended that VA take several steps to improve policy and training to protect information and information systems. Some recommendations remain open. The review also noted security problems with contracting for services, which give the contractor access to protected VA systems and systems of records. Sensitivity level designations for contractor personnel in VHA are determined by each Veterans Integrated Service Network (VISN) office, which has resulted in inconsistent and inaccurate designations. Many contracts reviewed did not include certain provisions to protect the information or the systems, and as a result, contracting personnel were given access without proper training or clearances.

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

ESTIMATED RESOLUTION TIMEFRAME: FY 2010

VA Information Security Program Reviews	
Key FY 2007 Actions	Anticipated Impacts
Began to implement the Data Security, Assessment and Strengthening of Controls Program (DS-ASC) to **centrally manage** implementation, enforcement, and remediation of **IT security controls** throughout the Department.	Establish accountability for compliance with privacy and information security requirements and help prevent breaches of confidentiality and unauthorized use of veterans' sensitive and protected information.
Established the Office of IT Oversight & Compliance, which consolidated existing IT security inspection/compliance program activities into one office to assist the CIO in **centralized enforcement of VA IT security controls**.	Better compliance with existing laws and regulations regarding IT security.

VA Information Security Program Reviews	
Key FY 2007 Actions	Anticipated Impacts
Issued draft **VA Handbook 6500 Information Security Program,** which contains language specifying that contractor personnel are to be held to the same standards as VA employees and that information accessed, stored, or processed on non-VA automated systems are to be safeguarded.	Help ensure that sensitive data outside of VA's span of control are adequately protected.
Completed movement of the VA Central Office Data Center, which fully remediates **one of the 17 recommendations** contained in the FY 2005 FISMA Audit Report.	Decrease risk of environmental damage to VA Central Office Data Center assets.
Issued numerous IT memorandums, directives, and policies addressing several high-risk areas involving the **use of sensitive information.**	Establish and/or strengthen controls over the protection of VA sensitive information.
Updated and improved VA Cyber Security and Privacy Awareness **training modules.**	Increase user awareness of the requirements associated with information security and the protection of VA sensitive information.
Updated system security plans for over **600 VA systems** to reflect existing and planned security controls.	Allow managers to document and remediate shortcomings in existing controls. In addition, prepare systems for certification and accreditation.
Implemented actions to address recommendations in the OIG report concerning "Loss of VA Information, at the VA Medical Center, Birmingham, Alabama," such as posting a **research privacy checklist** on the Web for use by the VHA Office of Research Oversight staff and the VA research community.	Provide specific application of VA information privacy requirements in the research setting and enable research facilities to conduct self-assessments to ensure continuing compliance and improvement.
Developed a checklist for **research information security** that is used by VA research facilities as well as IT review teams.	Strengthen controls over the use, storage, and transmission of VA research data.
Conducted **site visits** at VA medical facilities; facilities must develop a remedial action plan to address any issues of noncompliance.	Provide direct oversight and independent evaluation of compliance with research information privacy and security requirements and ensure prompt correction of identified deficiencies. Prospect of on-site inspections motivates facilities to ensure continuous compliance. Improve IT security controls at VA medical facilities.
Collaborated with the wider academic community and other federal agencies that support biomedical research to create alignment with **federal information security managemen**t requirements for research involving veterans.	Help ensure that veterans' information is afforded the highest standard of security nationwide.
Handbook 1200.12, "Use of Data and Data Repositories in VA Research," placed more stringent requirements on the use and storage of VA research data.	Establish a baseline set of controls that will better protect the use, transmission, and storage of veterans' sensitive research data.

VA Information Security Program Reviews	
Key FY 2007 Actions	Anticipated Impacts
Over 20,000 VA research staff completed mandatory training on privacy and security requirements developed specifically to address the complex needs of the research environment.	Provide specific application of VA information privacy and security requirements to long-term storage and use of veterans' information for research, thereby helping prevent breaches of confidentiality and unauthorized use of veterans' sensitive and protected health information. Increase awareness of the requirements for protection of VA sensitive information located in research facilities.

VA Information Security Program Reviews	
Key FY 2008 Actions	Anticipated Impacts
Certify and accredit over 600 Department information systems.	Allow officials to better understand and manage the risks associated with the operation of VA information systems.
Centralize enforcement and remediate IT security deficiencies via the DS-ASC.	More effective and timely remediation of IT security deficiencies.
Inspect IT controls at VA facilities.	Improve IT security controls.
Install PKI for all medical care staff and develop a plan to have PKI implemented for medical care contractors.	Help ensure the confidentiality, integrity, and availability of VA sensitive data by providing stronger controls over the transmission and/or storage of sensitive data.
All medical care employees and contractors will complete **annual privacy and security training**.	Help ensure the confidentiality, integrity, and availability of veterans' data through better awareness of the security and privacy requirements associated with the protection of VA sensitive medical and research information.
Institute a requirement for **nationwide certification** of all active research protocols for compliance with security standards. Continue mandatory education of the VA research community on privacy and security requirements.	
Finalize a directive to mandate the appointment of a Facility Information Security Officer and a Privacy Officer to the facility Institutional Review Boards (IRBs), or mandating their inclusion in the process for reviewing proposals for all external IRBs.	The draft directive provides practical guidance and appears to be executable in VHA health care facilities; however, it may be difficult to implement with external IRBs.
Establish a full-time Privacy Officer at all major VHA health care facilities.	Provide specific application of VA information security requirements in the research setting and make individual research investigators and medical facilities aware of these requirements, thus fostering accountability of individual investigators and helping prevent breaches of confidentiality and unauthorized use of veterans' sensitive and protected health information.
Centralize data access management of VA national data containing social security numbers to ensure compliance and improve oversight.	
Participate in numerous **educational** and **training** sessions to reach out to key members of the research community about the requirements for **research information security**.	

VA Information Security Program Reviews	
Key FY 2008 Actions	Anticipated Impacts
Communicate to medical facilities that they must use VHA Directive and Handbook 0710 to address sensitivity level designations.	Strengthen the security and protection of VA information systems by ensuring the suitability of personnel having access.

APPENDIX

The Appendix lists selected reports pertinent to the five key challenges discussed. However, the Appendix is not intended to encompass all OIG work in an area.

HEALTH CARE DELIVERY

Audit of VHA's Part-Time Physician Time and Attendance
(OIG Report 02-01339-85, April 23, 2003)

Healthcare Inspection, VHA's Community Residential Care (CRC) Program
(OIG Report 03-00391-138, May 3, 2004)

Healthcare Inspection, Review of Quality of Care, Department of Veterans Affairs James A. Haley Medical Center, Tampa, Florida
(OIG Report 05-00641-149, June 1, 2005)

Audit of the Veterans Health Administration's Outpatient Scheduling Procedures
(OIG Report 04-02887-169, July 8, 2005)

Review of Access to Care in the Veterans Health Administration
(OIG Report 05-03028-145, May 17, 2006)

Healthcare Inspection, Follow-Up Review of the Quality of Care at the James A. Haley Medical Center, Tampa, Florida
(OIG Report 05-00641-166, July 12, 2006)

Healthcare Inspection, Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation
(OIG Report 05-01818-165, July 12, 2006)

Healthcare Inspection, Access to Post-Traumatic Stress Disorder Treatment, James J. Peters VA Medical Center, Bronx NY
(OIG Report 05-03571-187, August 11, 2006)

Review of Recurring and Systematic Issues Identified During Combined Assessment Program Reviews at VA Facilities January 1999 through August 2006
(OIG Report 06-03441-227, September 25, 2006)

Alleged Documentation Irregularities and Human Subjects Protection Violations at Bay Pines VA Healthcare System, Bay Pines, Florida
(OIG Report 06-01952-63, January 23, 2007)

Healthcare Inspection, Research Practices at Carl T. Hayden VA Medical Center Phoenix, Arizona
(OIG Report 07-00589-118, April 20, 2007)

Healthcare Inspection Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention
(OIG Report 06-03706-126, May 10, 2007)

Administrative Investigation Loss of VA Information VA Medical Center Birmingham, Alabama
(OIG Report 07-01083-157, June 29, 2007)

Audit of the Veterans Health Administration's Outpatient Waiting Times
(OIG Report 07-00616-199, September 10, 2007)

Statement of Antonette Zeiss, Ph.D., Deputy Chief Consultant, Office of Mental Health Services
(House Committee on Oversight and Government Reform Hearing, May 24, 2007)

Veterans Benefits Administration Annual Benefits Report for Fiscal Year 2005
(September 2006)

Task Force Report to the President
(Task Force on Returning Global War on Terror Heroes, April 19, 2007)

VA and DoD Health Care: Opportunities to Maximize Resource Sharing Remain
(GAO Report GAO-06-315, March 20, 2006)

Post-Traumatic Stress Disorder: DoD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers
(GAO Report GAO-06-397, May 11, 2006)

VA and DoD Health Care: Efforts To Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans
(GAO Report GAO-06-794R, June 30, 2006)

VA Health Care: Spending for Mental Health Strategic Plan Initiatives Was Substantially Less Than Planned
(GAO Report GAO-07-66, November 21, 2006)

VA and DoD Health Care: Challenges Encountered by Injured Servicemembers During Their Recovery Process
(GAO Report GAO-07-606T, March 8, 2007)

VA and DoD Are Making Progress in Sharing Medical Information, but Are Far from Comprehensive Electronic Medical Records
(GAO Report GAO-07-852T, May 8, 2007)

BENEFITS PROCESSING

Review of State Variances in VA Disability Compensation Payments
(OIG Report 05-00765-137, May 19, 2005)

Review of Recurring and Systematic Issues identified During Combined Assessment Program Reviews at VA Facilities January 1999 through August 2006
(OIG Report 06-03441-227, September 25, 2006)

Audit of Veterans Benefits Administration's Pension Maintenance Program Administered by the Pension Maintenance Centers
(OIG Report 05-03180-111, March 30, 2007)

Task Force Report to the President
(Task Force on Returning Global War on Terror Heroes, April 19, 2007)

Veterans' Disability Benefits: Long-Standing Claims Processing Challenges Persist
(GAO Report GAO-07-512T, March 7, 2007)

Veterans Benefits Administration: Progress Made in Long-Term Effort To Replace Benefits System, but Challenges Persist
(GAO Report GAO-07-614, April 27, 2007)

Statement of Daniel L. Cooper, Under Secretary For Benefits (Joint Hearing before the Senate Committee on Veterans' Affairs and the Senate Committee on Armed Services, April 12, 2007)

Statement of Ronald R. Aument, Deputy Under Secretary for Benefits (House Committee on Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs Hearing, March 13, 2007)

Statement of Hon. William P. Greene, Jr., Chief Judge, U.S. Court of Appeals for Veterans Claims (House Committee on Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs Hearing, May 22, 2007)

A 21st Century System for Evaluating Veterans for Disability Benefits
(Institute of Medicine, May 7, 2007)

FINANCIAL MANAGEMENT

Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2006 and 2005
(OIG Report 06-01279-24, November 14, 2006)

Report to the Committee on the Budget from the Committee on Veterans' Affairs Submitted Pursuant to Section 301 of the Congressional Budget Act of 1974 on the Budget Proposed for Fiscal Year 2008
(March 1, 2007)

PROCUREMENT PRACTICES

Issues at VA Medical Center Bay Pines, Florida, and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)
(OIG Report 04-01371-177, August 11, 2004)

Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions
(OIG Report 05-01318-85, February 16, 2005)

Review of VA Implementation of the Zegato E-Travel Service
(OIG Report 04-00904-124, March 31, 2005)

Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study
(OIG Report 04-02330-212, September 30, 2005)

Audit of VA Acquisitions for Other Government Agencies
(OIG Report 04-03178-139, May 5, 2006)

Audit of the Veterans Health Administration's Acquisition of Medical Transcription Services
(OIG Report 04-00018-155, June 14, 2006)

Patient Financial Services System Contract Planning, Award, and Administration Review, VA Central Office
(OIG Report 06-03285-73, January 31, 2007)

Administrative Investigation, Contract Award and Administration Irregularities, Offices of Information & Technology and Acquisition & Materiel Management, VA Central Office
(OIG Report 06-02238-84, February 12, 2007)

Review of VA Central Incident Response Capability Contract Planning, Award, and Administration
(OIG Report 04-03100-90, February 26, 2007)

Audit of Alleged Mismanagement of Government Funds at the VA Boston Healthcare System
(OIG Report 06-00931-139, May 31, 2007)

INFORMATION MANAGEMENT

FY 2005 Audit of VA Information Security Program
(OIG Report 05-00055-216, September 20, 2006)

Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2006 and 2005
(OIG Report 06-01279-24, November 14, 2006)

Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans
(OIG Report 06-02238-163, July 11, 2006)

Administrative Investigation Loss of VA Information VA Medical Center Birmingham, Alabama
(OIG Report 07-01083-157, June 29, 2007)

FY 2006 Audit of VA Information Security Program
(OIG Report 06-00035-222, September 28, 2007)

FY 2009 Business Plan
(Corporate Franchise Data Center, May 2007)

OIG Contact and Staff Acknowledgments

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