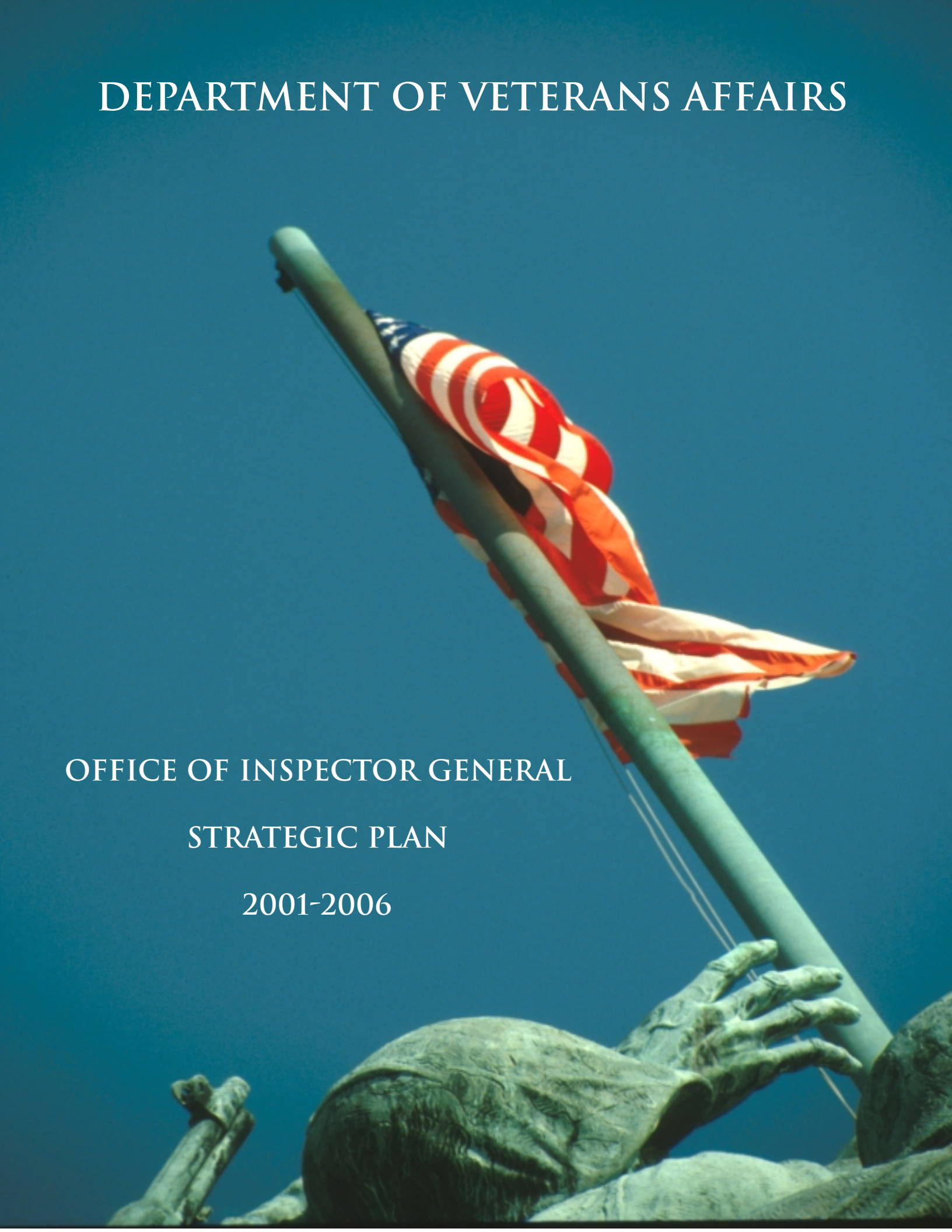
DEPARTMENT OF VETERANS AFFAIRS



OFFICE OF INSPECTOR GENERAL

STRATEGIC PLAN

2001-2006

October 2000

MESSAGE FROM THE INSPECTOR GENERAL

The environment in which the government operates today has evolved into one that has increased emphasis on maximizing performance, enhancing customer satisfaction, and producing results. The Department of Veterans Affairs (VA) has been and continues to be at the forefront of this evolution. With this has come significant change in the way VA operates and considerable challenge for continued improvement in the future.

In this changing environment, the Office of Inspector General (OIG) is resolved to ensuring VA programs are efficiently and effectively managed, and free of fraud, waste and abuse. The OIG will aggressively investigate, arrest, and seek prosecution of persons perpetrating crimes impacting VA programs. We are committed to keeping abreast and fully understanding the key issues facing VA, and focusing our resources on these issues in order to maximize the impact we have on helping VA meet its challenges. The OIG Strategic Plan 2001-2006 provides the structure, goals and strategies for fulfilling these commitments.

The goals established in the OIG strategic plan represent the highest priority concerns facing VA and provide the framework that will guide our oversight as we enter the 21st century. At the forefront of this plan are strategic goals concerning health care, benefits processing, financial management systems, procurement practices, and information technology. In addition to VA's strategic goals, the thread of working together as One VA is woven throughout our objectives.

Strategic planning is an ongoing process. We will continually reassess our goals and strategies and update our plan as necessary to ensure that our focus remains relevant, timely, and responsive to the priorities facing VA.

The OIG remains dedicated to working with the Secretary of Veterans Affairs and the Congress. By exceeding the expectations of our customers, we will be an ever-growing influence in helping VA achieve its goals. We are committed to achieving our strategic goals and promoting positive change in the veterans affairs community.

(original signed by:)
RICHARD J. GRIFFIN

VA OIG STRATEGIC PLAN 2001-2006
SUMMARY OF GOALS

Health Care Delivery

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

Benefits Processing

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

Financial Management Systems

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

Procurement Practices

Identify opportunities to enhance the effectiveness and efficiency of VA's acquisition programs in meeting user needs and ensuring the best possible price, and help eliminate opportunities to commit fraud and other illegal acts in the procurement process by investigating and prosecuting criminal activity to the fullest extent of the law.

Information Management

Determine if VA's information systems are adequately protected and provide accurate, complete, and timely information in order to improve performance, cut costs, and enhance customer service; and investigate fraud and other computer related crimes against VA.

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CHAPTER I
MISSION, ORGANIZATION, AND RESOURCES

The Department of Veterans Affairs (VA)

In one form or another, American governments have provided veterans benefits since before the Revolutionary War. VA's historic predecessor agencies demonstrated our Nation's long commitment to veterans. The Veterans Administration was created in 1930 when Public Law 71-536 consolidated the Veterans' Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers into one independent agency. The Department of Veterans Affairs (VA) was established on March 15, 1989, when Public Law 100-527 elevated the Veterans Administration to Cabinet-level status.

MISSION

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

ORGANIZATION

VA has three Administrations that serve veterans.

- The Veterans Health Administration (VHA) is responsible for medical care, medical education, medical research, and backup to the Department of Defense.

- The Veterans Benefits Administration (VBA) is responsible for administering a program of benefits that include compensation and pension, education, vocational rehabilitation and employment services, insurance coverage, housing programs, and other transition benefits and services.

- The National Cemetery Administration (NCA) provides interment, memorial services, and maintains veteran cemeteries as a permanent tribute from a grateful nation.

RESOURCES

While most Americans know of VA, few realize that it is the second largest Federal employer. For FY 2000, VA employed over 200,000 full time employees. Including its part time employees, VA's total workforce exceeds 240,000 individuals, over 13 percent of the Federal workforce. VA's budget for FY 2000 was $45.5 billion. There are an estimated 25.9 million living veterans.

As one of the largest health care systems in the United States, VHA employs approximately 187,000 employees. Health care accounted for $19.3 billion (approximately 42 percent) of VA's budget in FY 2000. VHA provided care to an average of 58,100 inpatients daily, and slightly more than 40 million episodes of care were provided to outpatients. There are 172 medical centers, 766 outpatient clinics, 132 nursing home units, and 40 domiciliaries.

Veterans benefits were funded at $25.5 billion (almost 56 percent) of VA's budget in FY 2000. VBA oversees the delivery of benefits and services at 58 regional offices and centers throughout the United States, Puerto Rico and the Philippines. Over 11,500 VBA employees provide benefits to veterans and their families. About 2.6 million veterans and their beneficiaries receive compensation benefits valued at $19 billion. Also, over $3 billion in pension benefits are provided to veterans and survivors. VA life insurance programs have 4.5 million policies in force with a value of over $450 billion. Almost 280,000 home loans were guaranteed in FY 2000, with a value of almost $32 billion.

NCA operated and maintained 119 cemeteries and employed about 1,400 staff in FY 2000. Operation of NCA and all of VA's burial benefits accounted for approximately $300 million of VA's $45.5 billion budget. Interments in VA cemeteries continue to increase each year, with about 83,300 estimated in FY 2000. Approximately 343,000 headstones and markers were provided for veterans and their eligible dependents in VA cemeteries, state veterans' cemeteries, and private cemeteries.

VA Office of Inspector General (OIG)

VA's OIG was administratively established on January 1, 1978, to consolidate audit, investigation, and related operations into a cohesive, independent organization. In October 1978, the Inspector General Act (Public Law 95-452) was enacted and established a statutory Inspector General (IG) in VA.

The Inspector General Act of 1978 states that the IG is responsible for: (i) conducting and supervising audits and investigations of VA programs and operations; (ii) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect fraud and abuse in, the programs and operations of VA; and (iii) keeping the Secretary and the Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action. The Inspector General Act Amendments of 1988 provided the IG with a separate appropriation account and a revised and expanded procedure for reporting semiannual workload to Congress. The IG has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements with VA.

In performing its mandated oversight function, the OIG conducts investigations, audits, and health care inspections of VA activities. In doing so, OIG employees strive to be leaders and innovators, and to perform their duties fairly, honestly and with the highest professional integrity. The OIG's oversight efforts emphasize the goals of the Government Performance and Results Act for creating a Government that works better and costs less. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer and results oriented.

MISSION STATEMENT

The OIG is dedicated to helping VA and Congress ensure that veterans and their families receive the care, support, and recognition they have earned through service to their country, and to do so in an environment that is efficient, effective, and free from criminal activity.

ORGANIZATION

The OIG is organized into three line elements: the Offices of Investigations, Audit, and Healthcare Inspections; and one staff element to provide administrative and managerial support. The three line elements join to perform Combined Assessment Program (CAP) reviews that consolidate the knowledge and skills of the offices of Audit, Healthcare Inspections and Investigations to perform independent and objective evaluations of selected health care and benefits field operations on a cyclical basis. Following are descriptions of the responsibilities of these components. See Appendix A for the OIG organizational chart.

Office of Investigations

MESSAGE FROM THE ASSISTANT INSPECTOR GENERAL FOR INVESTIGATIONS

> "The Office of Investigations uses both a reactive and proactive approach to aggressively pursue prosecution of persons perpetrating crimes impacting VA programs. In order to determine the effectiveness of our efforts in this area, strategic goals and measurement criteria have been established."

The Office of Investigations is responsible for performing investigations of alleged criminal activity in VA programs and operations. In accordance with statutory requirements, criminal violations are referred to the Department of Justice or other appropriate State or local authorities for prosecution. In addition, the office conducts administrative investigations into allegations concerning senior officials and other high profile matters. Following is the mission statement for the Office of Investigations.

> *Conduct investigations of criminal and administrative activities in the programs and operations of the Department of Veterans Affairs in an independent and objective manner; and seek prosecution, administrative action, and/or monetary recoveries where appropriate.*

Office of Audit

MESSAGE FROM THE ASSISTANT INSPECTOR GENERAL FOR AUDIT

> "Our focus is on the value-added outcomes that we expect to achieve through our work. Our success will be measured by the

impact we have on improving VA operations, ensuring accountability and stewardship, and maximizing overall agency performance."

The Office of Audit provides independent evaluations of VA's programs and operations by performing financial and performance audits. Performance audits include economy and efficiency, compliance, and program results. Financial audits include financial statement and financial related audits. Following is the mission statement for the Office of Audit.

Improve the management of VA programs and activities by providing our customers with timely, balanced, credible and independent financial and performance audits that address the economy, efficiency, and effectiveness of VA operations; and, that identify constructive solutions and opportunities for improvement.

Office of Healthcare Inspections

Message from the Assistant Inspector General for Healthcare Inspections

"The strategic plan for the Office of Healthcare Inspections is to critically evaluate VA health care programs, including quality assurance programs and activities, to ensure VA is providing high quality services to our veterans now and in the future."

The Office of Healthcare Inspections evaluates quality assurance programs and patient care issues in VA's health care delivery system. Inspections include independent focused reviews of individual health care related Hotline issues, program evaluations of nationwide specialized VA treatment programs, and oversight of internal VHA quality management and patient safety operations. Following is the mission statement for the Office of Healthcare Inspections.

Promote the principles of continuous performance improvement to provide effective inspections, oversight and consultation to enhance and strengthen the quality of VA's health care programs for the well-being of veteran patients and their families.

Office of Management and Administration

Message from the Assistant Inspector General for Management and Administration

> "Strategic planning is a continuous process aimed at keeping current with and fully understanding the key issues and concerns facing VA. This allows us to develop and perform projects that have the greatest possible impact on improving VA."

The Office of Management and Administration provides support services for the OIG nationwide. These services include financial management, human resources management, administrative support and information technology management. Office of Management and Administration responsibilities include operation of the OIG Hotline, development of OIG policy and procedures, report follow-up and strategic planning. Following is the mission statement for the Office of Management and Administration.

> *Maximize OIG results by providing outstanding management, planning and support services to all OIG employees, and across every operational element.*

OIG RESOURCES

FY 2000 funding for OIG operations was $45.7 million, with $43.2 million from appropriations and $2.5 million through reimbursable agreements. Approximately 75 percent of the total funding is for salaries and benefits; 5 percent for official travel; and the remaining 20 percent for all other operating expenses. Allocated full time equivalent (FTE) for FY 2000 staffing plan was 360 FTE. In addition, the OIG performs a contract review function for VA on a reimbursable basis, with an additional 24 FTE.

CHAPTER II
STRATEGIC PLANNING

VA is faced with the challenge of responding to a rapidly changing environment. For example, an aging veteran population is creating increased demand for long-term care. Changes in the demographics of veterans raise new challenges in providing access to benefits and services. VA's continued evolution of treating patients in an expanded outpatient care setting has a direct effect on the utilization and role of VA medical centers. There also exists a growing demand for burial space, especially near large metropolitan areas.

Issues such as rapidly escalating costs for pharmaceuticals and supplies, and the growing use of government purchase cards have raised serious questions over how best to control costs. Differing perspectives concerning the advantages of buying locally for convenience versus centrally for economical reasons have resulted in the application of a wide variety of procurement practices throughout VA.

There is increased emphasis in customer satisfaction, and a demand for greater accountability and improved results. In VBA, a case in point is the fact that lengthy claims processing times and internal control concerns have put the timeliness and quality of benefit payments at the forefront of some of VA's most important and complicated issues.

This is all occurring at a time when a large percentage of the Federal workforce is approaching retirement age, and competition from the private sector for highly qualified employees is greater than ever. In response to these challenges, VA has already begun realigning organizational structures; developing new program and service delivery strategies; adopting state-of-the-art technologies; improving financial and performance data for management decision making; and employing new human capital practices. The strategies developed today to respond to these challenges will have implications far into the future, not only for the way VA operates, but also for the role the OIG will play in overseeing VA programs and activities.

In this changing environment, the challenge for the OIG is to stay abreast of VA's goals and objectives and have a clear and comprehensive

understanding of the strategies and approaches employed by VA to achieve its goals. The OIG has developed and implemented a strategic planning process that focuses on helping VA achieve its strategic goals in the most efficient, effective, and economical way.

At the core of the OIG strategic planning process is the intent to have the greatest impact possible in helping VA achieve its goals. Meeting this challenge requires a strategic planning process that identifies and focuses available resources on the key issues that are important to VA, Congress and the veterans we serve. The goals and objectives of the OIG strategic plan provide a template for directing our resources at those issues.

In the coming years, the OIG will focus its efforts on the following major issues:

1. Access to High Quality and Safe Health Care
2. Timeliness and Accuracy of Benefits Claims Processing
3. Reliability of Financial Management Systems
4. Efficient and Economical Procurement Practices
5. Effective and Secure Information Technology

For each of these major issue areas, this plan defines our strategic goals, the strategies for achieving these goals, and the performance measures we will use to measure success against the goals. Achievement of each goal is supported by a combination of operational objectives that reflect a collaborative and coordinated effort between Audit, Healthcare Inspections, and Investigations. The plan also identifies the external factors that may affect the OIG's ability to accomplish its goals and objectives.

The VA OIG Strategic Plan 2001-2006 was developed in accordance with the Government Performance and Results Act of 1993. The mission statement and strategic goals set forth in this plan lay the foundation for what the OIG strives to achieve in the years to come and the overall impact we hope to realize.

OIG strategic planning is an ongoing process that requires measurement and adjustment. As goals are achieved or priorities change, the OIG strategic plan will be revised through a fully integrated and collaborative process that ensures we perform projects that address issues that are important and useful to our customers.

The OIG will maintain an organizational structure that reflects our mission and is functionally aligned to achieve our strategic goals. In pursuing these goals, OIG oversight efforts will focus on systemic issues having the potential for improving overall program performance. While the OIG remains a multidisciplinary organization, we have made a deliberate choice to move closer to an organization where we combine our various disciplines and areas of expertise to achieve better results. In doing so, we will share one set of strategic goals, take a proactive approach in addressing issues, and present results in a positive and timely manner.

CHAPTER III
STRATEGIC GOAL # 1
HEALTH CARE DELIVERY

STRATEGIC ASSESSMENT

The primary mission of the Veterans Health Administration (VHA) is to serve the health care needs of eligible veterans by providing quality inpatient, outpatient, and long-term health care services. During FY 2001, VHA will spend more than $21 billion and employ a workforce of over 180,000 people to provide health care and related services to over 2.8 million veterans.

Historically, VA's health care has been provided through a hospital-based delivery system. However, in recent years VHA restructured health care delivery to emphasize managed care through an extended network of community-based outpatient clinics and ambulatory care units. This transition has raised new issues concerning the utilization of hospitals and the role they will play in addressing the medical needs of an aging veteran population.

It has been reported that VA's health care infrastructure does not meet its current and future needs. Specifically, some of VA's medical facilities are deteriorating, inappropriately configured, or no longer needed because of VHA's shift to providing primary care in an outpatient setting. Unneeded space creates a financial drain on VHA resources and unproductive assets siphon valuable resources away from medical services for veterans.

During the next decade VHA will be challenged to provide efficient and effective long-term care and geriatric services to an aging veteran population. Between 1990 and 2000, the veteran population over 65 years of age increased from slightly more than 7 million to 9.3 million veterans. By 2010, veterans will represent 66% of the U.S. male population over 85 years of age. In contrast, from 1990 through 2010, the number of younger veterans (those under 45 years of age) will show a significant decline from about 8.3 million to 3.3 million. These estimates will likely cause a dramatic shift in the demand for VA benefits and services.

In addition, VHA's transition to a greatly expanded ambulatory care/outpatient care setting, coupled with a realignment of regional management services

into 22 Veterans Integrated Service Networks (VISNs), has increased the challenge to provide high quality health care services through a redesigned health care delivery system. Such challenges serve to heighten OIG concern over the potential for health care vulnerabilities in the years to come. Health care quality management is one of the most serious and potentially volatile challenges facing VA. The OIG is concerned over the potential for serious errors to increase as VA transitions into the more rapid pace of patient care in the ambulatory care setting.

Providing safe, high quality medical care, reasonable patient waiting times, and accessibility to care are just some of the fundamental delivery of service issues that present challenges on a continuing basis. Effectively dealing with these challenges requires vigilant management and evaluative oversight. For example, VHA must maintain a fully functional Quality Management (QM) program that ensures high quality patient care and safety, and safeguards against the occurrence of adverse events.

Shifting the focus of health care delivery from inpatient to outpatient care is a key component of VHA's ability to deliver high quality and safe health care. To accomplish this successfully will require reallocating a significant percent of resources to ambulatory care. Such a shift is contingent upon successful restructuring, as well as upon future need for inpatient care. In addition, it is expected that inpatient bed days of care will continue to decline, and that VHA's health care delivery system will be able to meet projected demand arising from an expanded and improved eligibility system. Further resource gains will depend upon support from external stakeholders and VHA's ability to provide the tools and create the cultural climate necessary to bring about extensive changes in clinical processes. Continuing the trend of increasing revenue growth from non-appropriated sources will require a substantial increase in medical care recoveries and other reimbursements.

Congress and OMB have established new guidelines and requirements for agencies to use in improving the acquisition and management of capital assets. Historically, VA has not had a comprehensive capital planning process. However, in response to the new Federal requirements, VA and VHA have undertaken several initiatives to address capital investment plans. However, recent OIG evaluations of VA's asset realignment challenges have found that, while VA has taken steps in the right direction, it continues to struggle to address those challenges. Deciding where new health care facilities such as outpatient clinics are to be located, how best to deal with

under-utilized hospitals, and allocation of staff and resources for major equipment and technology purchases are a few of the issues at the forefront of capital asset planning.

Providing access to high quality health care is an ongoing issue of high priority to VA and continues to be of great public and congressional importance. To determine how well VHA is meeting its challenges and to identify opportunities to improve the safety, quality and management of VHA's health care delivery system, the OIG plans to perform a series of audits, healthcare inspections, and investigations over the next 6 years. Following is the OIG's strategic goal and related objectives that will guide our oversight efforts in the area of access to health care.

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

Audit Objectives:

- Evaluate how well VHA is adapting to the changing demographics of an aging veteran population.
- Evaluate VHA's planning for realignment of capital assets to enhance veterans' access to health care services.
- Evaluate VHA's success in moving hospitalized veterans to appropriate community living arrangements.
- Assess how efficient and economical VHA's fee-basis program is in serving veterans' needs.
- Evaluate how well VHA's health care delivery system addresses the special needs of women and homeless veterans.
- Review the allocation of resources for clinical and administrative staff to determine if resource imbalances have been corrected with VHA's implementation of the Veterans Equitable Resource Allocation Model.

- Evaluate the efficiency and effectiveness of VHA's operations to increase revenue growth from non-appropriated sources through medical sharing, increased medical care recoveries and other reimbursements.

- Evaluate the extent and effectiveness of VISNs' efforts to integrate and realign health care facilities and services.

- Evaluate opportunities to better use under-utilized hospital space through expansion, consolidation, or re-engineering of services.

- Evaluate VHA's effectiveness for allocation of resources for facilities, equipment, and information technology.

- Evaluate the accuracy, completeness, and security of patient clinical information and VHA's ability to ensure this information is available when needed.

Healthcare Inspection Objectives:

- Determine how well VHA's quality management program ensures patients receive high quality health care outcomes.

- Evaluate long-term care provided to veteran patients, to include nutritional care, patient safety/restraints usage, and contract nursing home quality oversight.

- Assess acute medical and surgical care, to include pain management, ordering of unnecessary diagnostic testing, and diabetic patient glucose monitoring.

- Review the ambulatory care program, to include supervision of nurse practitioners and physician assistants, dangerous drug pairs/medication errors, medication education, and inventory of high-cost drugs.

- Review the Community-Based Outpatient Clinic Program to include integration of quality management activities with parent medical centers, practitioner credentialing and privileging, patient safety, and consultation appropriateness.

- Evaluate mental health and behavioral sciences procedures, to include prescribing narcotics to psychiatric patients, physician care and medical consultation and back-up support, violence prevention, and restraints and seclusion.

- Evaluate the effectiveness and propriety of internal VHA quality management and patient safety offices, including the Office of the Medical Inspector, the Office of Performance and Quality, the National Center for Patient Safety, and the Office of Research Compliance and Assessment.

Investigation Objectives:

- Investigate fraud and other criminal activities committed against VHA to include actions such as patient abuse, theft of Government property, drug diversion, and bribery/kickback activities by employees and contractors doing business with VA.

- Aggressively pursue crimes occurring at VA facilities throughout the nation to help ensure safety and security for those working in or visiting VA medical centers and outpatient clinics.

- Conduct targeted proactive computer matching initiatives on a nationwide basis in order to detect, investigate, and prosecute criminal violations against VHA in a timely manner.

- Perform a nationwide proactive investigative effort of the VHA mail-out prescription program to determine if drugs are being illegally diverted.

- Investigate workers' compensation fraud, to include claimants and others involved in defrauding both Federal and State programs.

STRATEGY

As VHA's infrastructure continues to evolve to meet the future health care needs of veterans, the OIG's oversight role will be to ensure that the VA medical care appropriation is appropriately utilized to effectively and efficiently provide maximum access to quality health care services. The OIG will determine whether VHA programs and operations are performing economically and efficiently, and whether management controls are in place to provide the necessary assurances that quality of care goals are being achieved and maintained.

Through a coordinated effort involving audit, investigations, and health care inspection expertise, the OIG will identify best practices and opportunities for revising policies and practices, streamlining programs, achieving savings and other improvements impacting management, administrative and clinical

issues. This will be achieved through a series of national audits and program evaluations aimed at systemic improvements, as well as recurring Combined Assessment Program (CAP) reviews.

CAP reviews are an integral part of the OIG's strategy to ensure that high quality health care is provided to our nation's veterans. CAP reviews combine the knowledge and skills of the offices of Audit, Healthcare Inspections and Investigations to perform independent and objective evaluations of selected medical center operations on a cyclical basis. The primary focus of these reviews is patient care and quality management, financial and administrative management, and fraud prevention.

Public Law 100-322 requires the OIG to oversee, monitor, and evaluate the operations of VHA's quality assurance programs and the activities of the Office of the Medical Inspector. In response, the OIG established procedures for reviewing and commenting on the work of the Medical Inspector and VHA's quality management infrastructure. These reviews, done in concert with the national audits and program reviews, will contribute to assessing and improving access to safe and high quality care.

Another aspect of our strategy involves addressing allegations reported to the OIG Hotline pertaining to a wide variety of health care issues, such as allegations involving substandard quality patient care. Our goal is to independently address as many allegations as possible, within the capabilities of staffing resources. Hotline cases involving health care issues that cannot be conducted by the OIG will be forwarded to VHA for review and response. The OIG will review the adequacy of these responses and request follow-up, if appropriate. The results of our audits, healthcare inspections, investigations, CAP reviews and Hotline cases will be detailed in written reports that are objective and timely, and highlighted in our Semiannual Report to Congress. OIG products will provide VHA managers with recommendations aimed at improving the management, access and quality of health care.

The OIG will also take an aggressive approach to reducing fraud by conducting regularly scheduled fraud integrity awareness briefings that will ensure VHA officials and employees are aware of the types of crimes occurring at VHA facilities and the proper procedures for referring allegations of criminal conduct to the OIG. Specific emphasis will be placed on ensuring that qualified health care professionals review allegations of patient abuse, and that those instances rising to the level of criminal conduct are expeditiously investigated. We will increase liaison with VA Police and

Security Services by emphasizing joint investigative projects. When required or as needed, crimes such as drug diversion will be fully coordinated with appropriate Federal and local law enforcement authorities. We will aggressively pursue crimes against VA and seek prosecution to the fullest extent of the law.

We will work to prevent fraud by identifying program weaknesses and making recommendations for systems' corrections that will help eliminate opportunities to commit fraud and other illegal acts. We will improve the deterrence of fraud by publicizing successful criminal and civil prosecutions, penalties and sanctions involving violations of the laws and regulations governing VA programs.

PERFORMANCE MEASURES

To assess the outcome and effectiveness of OIG performance in terms of meeting our strategic goal, we have adopted the following performance measures.

Audit Measures:

- Number of Strategic Objectives Met
- Number of National Audits Completed
- Number of CAP Reviews Completed
- Reported Monetary Benefits
- Systemic Improvements Achieved
- Impact on VHA Achievement of Strategic Goals
- Customer Satisfaction Surveys

Healthcare Inspection Measures:

- Number of Strategic Objectives Met
- Number of Program Evaluations Issued
- Systemic Improvements Achieved
- Hotline Cases Completed
- Customer Satisfaction Surveys

Investigation Measures:

- Number of Strategic Objectives Met
- Number of Proactive Investigations
- Number of Criminal Cases Closed

- Number of Arrests, Indictments and Convictions
- Reported Monetary Benefits
- Number of Administrative Investigations Completed
- Number of Administrative Actions Taken
- Number of Fraud Awareness Briefings
- Customer Satisfaction Surveys

IMPACT

The OIG's audits, inspections, and investigations support VHA managers in meeting their goals and objectives by improving performance and accountability. OIG reports will detail how well programs and functions are working; whether funds are expended efficiently, effectively and in accordance with public law; and whether illegal or improper activities are occurring. Our work will assess the effectiveness of VHA in responding to the changing demographics of an aging veteran population by ensuring that facilities and services are located where there is the greatest need, and that hospitals are fully utilized through realignment, restructuring, conversion and/or consolidation. OIG recommendations, consultations, and suggestions will focus on expanding access to clinical care; improving the quality of care; reducing costs; improving the non-appropriated revenue stream; improving the safety of VA health care; reducing fraud; and equitably allocating funds according to the needs of veterans.

CHAPTER IV
STRATEGIC GOAL # 2
BENEFITS PROCESSING

STRATEGIC ASSESSMENT

For the past quarter century, VBA has struggled with the timeliness, accuracy and quality of its claims processing, particularly in the compensation and pension (C&P) programs. Although some improvement has occurred in recent years, VBA continues to face high workload backlogs, unacceptable claim processing times, and a high error rate. The inventory of pending claims for FY 2000 averaged about 360,000, and it took about 185 days for claims to be processed. VBA's strategic objective is to process claims that require rating action at an average of 74 days.

In recent years, VBA has experienced an increase in the number of disabilities claimed by each veteran, which takes more time to adjudicate. The average number of disabilities claimed increased to 4.8, and it is not unusual for VBA to receive claims listing 20 to 30 separate conditions for evaluation. This, along with the impact of decisions by the Court of Appeal for Veterans Claims requiring increased documentation and analysis on the reasons and bases for VBA claims decisions, has hindered VBA's efforts to reduce processing time to an acceptable level and bring the number of pending claims under control.

Although VBA managers have taken a number of steps to restructure their benefit delivery operation, they have yet to see a major reduction in the timeliness and quality of claims processed. Their movement to a claims manager concept whereby an individual, or team of individuals, handle a case from beginning to end has yet to produce the expected decrease in their case load and timeliness. However, the initial customer surveys show an increase in customer satisfaction reported by those whose cases were handled by offices that have already implemented the case manager concept.

In its attempt to restructure, VBA has offered a variety of early out and buy out offers to its employees throughout most of the last decade. However, these programs have generally been restricted to non-adjudicative personnel. This has allowed VBA to retain those individuals who are most closely

associated with claims processing. To address the pending caseload, adjudicative personnel have continually been requested to work overtime. While this has helped keep the caseload somewhat manageable, it has forced VBA to consider and implement a number of succession planning initiatives.

To a great extent, the VBA workforce is constantly fighting a battle to keep on top of claims processing. As a result, the potential is ripe for overlooking or ignoring appropriate management controls that go a long way to preventing waste, fraud and abuse from occurring in the delivery of benefits and services. The recent disclosure by the OIG that three VBA employees embezzled nearly $1.3 million by exploiting weaknesses in the C&P benefit program has placed increased concern on identifying and correcting internal control weaknesses that might facilitate or contribute to fraud in the C&P program. While this example shows the potential for fraud, waste, and abuse within VBA, it also demonstrates the need for external review of VBA to ensure not only the proper management of benefits delivery, but also to evaluate the adequacy and effect that reengineering efforts have on operations.

In addition to compensation and pension issues, VBA strives to achieve excellence in the effective and efficient administration of its other business lines: vocational rehabilitation and employment, education, housing and insurance. For example, VBA has established a goal to improve the ability of veterans to purchase and retain a home through the Loan Guaranty Program. Managing this program is a significant undertaking with almost 280,000 loans being guaranteed in FY 2000, at a value of about $32 billion. In recent years, audit reports have questioned whether VA has adequate control and accountability over direct loan and loan sales activities within VA's Housing Credit Assistance program. Concern has also been raised over whether VBA's vocational rehabilitation program has yielded acceptable results in finding jobs for seriously disabled veterans. Improving the quality, management and efficiency of these programs is a continuing oversight responsibility of the OIG. As such, the OIG will periodically review high profile issues that relate to these business lines.

Following is the OIG's strategic goal and related objectives that will guide our oversight efforts in the area of benefits delivery.

STRATEGIC GOAL: **Improve the delivery of benefits and services by identifying opportunities to improve the quality, timeliness and accuracy of benefits processing; and reduce fraud in the delivery of benefits through proactive and targeted investigative efforts.**

Audit Objectives:

- Evaluate the efficiency and effectiveness of VBA's Business Process Reengineering by assessing work processes, organizational structure, and integration of operations.

- Verify installation and use of technology at VBA regional offices, including functionality after installation, staff training, actual usage of technology, and the actual savings or performance improvement derived from the technology.

- Evaluate the use of information management and technology solutions in support of the Business Process Reengineering effort and the impact on the integrity and security of program data in VBA's information systems.

- Evaluate the use of technology and its impact on the timeliness and quality of claims processing. Evaluate the exchange of information within VA and with strategic partners to facilitate the delivery of benefits and services to veterans and their families.

- Determine if VBA's changes to claims processing procedures have effectively reduced benefit overpayments and improved timeliness.

- Assess the effectiveness of internal controls in preventing or deterring employee fraud in claims processing, and identify individuals fraudulently receiving compensation and pension benefit payments.

- Review management controls regarding the processing of claims to ensure fraudulent or improper payments are not released. Ensure appropriate controls are in place to prevent station management and/or station personnel from abusing their authority through inappropriate use of systems.

- Determine how promptly VBA terminates payments upon receiving notice of death or remarriage of a beneficiary, or notice of veteran incarceration.

- Evaluate the effectiveness of Memoranda of Understanding with other Federal and State agencies in the effort to reduce inappropriate benefit payments.

- Determine if Loan Guaranty Service effectively manages VA's direct loans and whether Loan Guaranty staff is properly underwriting refunded loans.

- Determine whether Loan Guaranty oversight of non-VA contractors safeguards VA's interests in the Loan Sales Program.

- Evaluate the exchange of information within VA and with strategic partners to facilitate the delivery of benefits and services to veterans and their families.

- Ensure VBA management has enacted personnel practices to ensure proper succession planning.

Healthcare Inspection Objectives:

- Review Vocational Rehabilitation Medical Records and Psychosocial Assessments to determine whether benefits were awarded based on the need for the vocational rehabilitation to overcome an employment handicap caused by the veterans' service-connected disabilities and that the employment objectives are feasible.

- Review the quality of medical examinations by VA and contract medical personnel for use in the compensation and pension adjudication process.

Investigation Objectives:

- Pursue fraud and other criminal activities committed against VBA to include actions such as compensation, pension, and education fraud; equity skimming; loan origination fraud; fiduciary fraud; and conflicts of interest.

- Implement a proactive investigative initiative, involving computer-matching efforts, to identify fraud in VBA benefits systems.

- Conduct an international investigative project to determine if VA benefits paid to veterans living overseas are being paid and received appropriately.

- Perform a nationwide investigative effort to determine whether benefits paid to veterans incarcerated in State and Federal correctional institutions are being adjusted in accordance with the law.

- Target a proactive investigative effort aimed at mortgage companies that prey on veterans for the purpose of taking advantage of the VA Home Loan Guaranty program.

- Identify and report patterns of fraud in order to correct control weaknesses that may have allowed the fraud to occur.

STRATEGY

The OIG will determine whether VBA programs and operations are performing economically and efficiently, and whether management controls are in place to assure VBA is accomplishing its benefits delivery mission. The OIG will identify best practices and opportunities for revising policies and procedures, streamlining programs, achieving savings, and other improvements impacting management and administrative issues. This will be achieved through national audits aimed at systemic improvements, and recurring Regional Office Combined Assessment Program (ROCAP) reviews.

ROCAP reviews are an integral part of the OIG's strategy to ensure that high quality benefit delivery is provided to our nation's veterans. ROCAP reviews of VBA's regional offices will provide independent and objective evaluations of selected office operations on a cyclical basis (6-8 year cycle) and fraud and integrity briefings to VBA employees. The primary focus of these reviews is program, financial, administrative management, and fraud prevention. Specific ROCAP pulse points that will be addressed at each regional office include:

- Veterans Service Center – Internal Control Vulnerabilities, Timeliness, Quality, Fiduciary Oversight
- Loan Guaranty – Construction, Processing, Property Management
- Vocational Rehabilitation – Internal Controls and Employment Rates
- Education – Timeliness, Quality, Compliance Surveys, Eligibility Determinations

- Information Resources Management – Systems Security
- Support Services – Accounts Reconciliation, Agent Cashier, Checks

Our strategy also involves addressing national issues to determine whether VBA programs and operations are performing economically and efficiently. Nationwide audits will be conducted of compensation claims processing, eligibility determinations, insurance program, loan guaranty underwriting, property management, education benefit program, vocational rehabilitation, information technology security, data validity, quality management systems, and financial accountability and management.

As a result of the large databases used in the delivery of benefits, a program of integrity reviews, data matches, and error checks will be used to focus our efforts into the most vulnerable areas of the benefits delivery system. VBA's benefits programs are subject to fraud by those who wish to take advantage of the system. For example, individuals submit false claims for service-connected disability; third parties steal pension payments issued after the unreported death of the veteran; individuals provide false information so that veterans qualify for VA guaranteed property loans; equity skimmers dupe veterans out of their homes; and, educational benefits are obtained under false representations.

The OIG will investigate crimes occurring in VBA programs and operations in a timely manner and refer those individuals responsible to appropriate officials for prosecution and/or appropriate administrative action. Through briefings, we will ensure VBA staff are aware of the types of fraud that can and have occurred, and the procedures for alerting the OIG of suspected fraud or other criminal violations. Proactive investigative projects will be conducted in collaboration with other elements of the OIG. Such efforts will include joint audit/investigative efforts into workers' compensation fraud; participation in loan guaranty fraud working groups to identify individuals who target Government loan programs for fraud; and computer searches to identify anomalies in VA's monetary benefit programs.

PERFORMANCE MEASURES

To assess the outcome and effectiveness of OIG performance in terms of meeting our strategic goal, we have adopted the following performance measures.

Audit Measures:

- Number of Strategic Objectives Met
- Number of National Audits Completed
- Number of ROCAPs Completed
- Reported Monetary Benefits
- Systemic Improvements Achieved
- Customer Satisfaction Surveys

Healthcare Inspection Measures:

- Meeting the Strategic Objective
- Contributions to ROCAP Reviews Issued
- Systemic Improvements Achieved
- Customer Satisfaction Surveys

Investigation Measures:

- Number of Strategic Objectives Met
- Number of Proactive Investigations
- Number of Criminal Cases Closed
- Number of Arrests, Indictments and Convictions
- Reported Monetary Benefits
- Number of Administrative Investigations Completed
- Number of Administrative Actions Taken
- Number of Fraud Awareness Briefings
- Customer Satisfaction Surveys

IMPACT

OIG efforts will support VBA in expediting and improving claims processing. A responsive, well-executed benefits award process will greatly enhance VBA's ability to manage its administrative and operational responsibilities. By monitoring and reporting on VBA's operation of compensation and pension activities, OIG can provide assurance that veterans, beneficiaries, and the nation's taxpayers are being well served. Evaluating and monitoring benefits delivery records and related data will enable us to report on the improvement in timeliness and help reduce the opportunity for fraud in VBA's delivery of benefits.

OIG efforts will assist VBA in improving the quality and efficiency of VBA regional offices. We will ensure a better use of funds, reduce errors and

improve the accuracy of benefit payments. Fraudulent claims and other crimes in these programs will be aggressively pursued, prosecuted to the fullest extent of the law and publicized to provide deterrent value.

CHAPTER V
STRATEGIC GOAL # 3
FINANCIAL MANAGEMENT SYSTEMS

STRATEGIC ASSESSMENT

The financial management organization in VA exists to provide support, systems, and processes to enable, foster, and ensure VA effectively and efficiently uses financial resources to aid in the delivery of high quality services to veterans and their families. The principal processes are the financial reporting control environment, payments, budget controls, compliance and operations controls. Vital to the accomplishment of financial management is the ADP control environment to include both general and application controls.

VA managers use 62 financial management systems and applications for managing VA resources. Currently, VA is undertaking a major effort to acquire a new financial management system that will integrate financial reporting to support the "One VA" concept. There are over 3,000 employees in financial management positions throughout VA Central Office in Washington, D.C., and VA field facilities. VA employees have stewardship responsibilities for an annual budget of approximately $45 billion and accountability for safeguarding assets totaling about $49 billion.

A good financial management system is important to help VA ensure that it has reliable and timely information on the costs of its programs. For example, VA needs accurate and timely information on costs of providing medical care to determine whether providing health care in a VA medical facility is cost effective. VHA's medical care, education, and research operations present specific challenges to financial management as VHA shifts from an inpatient based patient care delivery system to an outpatient model, the need for non-appropriated revenue increases, and better monitoring of funds for medical research becomes necessary.

VBA is faced with significant financial management challenges as it reengineers its business process to facilitate the accurate and timely delivery of services and benefits. Delivery systems for education, pension, compensation, housing credit assistance and insurance all require financial

management systems that accurately account for appropriation, revolving fund and trust fund expenditures, develop valid budget data, and provide the basis to maintain stewardship of funds. Also, VBA's benefits programs operate on annual appropriations that are supported by actuarial estimates, which are based on information developed through the financial management systems and that have a significant impact on VA's financial statements.

The National Cemetery Administration (NCA) financial management systems are challenged to provide accurate data for deferred maintenance and the need to fund new construction for burial sites.

The quality, accuracy and usefulness of financial data is an ongoing high-priority issue to the OIG and is of public and congressional importance as the Federal government strives to improve accountability and operate in a more businesslike manner. Congress emphasized the significance and importance of improving the integrity of financial reporting and financial management systems, and in using them for managing and safeguarding resources. The Chief Financial Officers (CFO) Act of 1990 requires Federal agencies develop and maintain reliable and accurate accounting and financial management systems, and that the VA Consolidated Financial Statements be audited annually.

In addition, the Federal Managers' Financial Integrity Act of 1996 (FMFIA) requires that management's process for evaluating and reporting on internal controls and accounting systems be assessed annually. The Government Performance and Results Act (GPRA) of 1993, the Government Management Reform Act (GMRA) of 1994, and the FMFIA further mandate that Federal agencies improve accountability by improving financial reporting systems, including requirements for improving information system security, and complying with Federal accounting standards. Evaluating compliance with these laws is an OIG oversight responsibility.

A major challenge facing VA, and a priority concern of the OIG, is VA's effort to replace its core accounting system with a new financial and logistics system. The new system is being designed to correct weaknesses identified with the VA's current system by replacing financial feeder systems which have limited or manual interfaces. OIG oversight efforts will need to focus on providing assurance that this new system meets financial and logistics core and user requirements, allows VA the flexibility to adapt to external and internal best business practices, and better supports and facilitates VA's

business and technology plans. Emphasis will also be placed on ensuring that data integrity is improved through the elimination of redundant financial data and that procedures are standardized for ease of use.

Following is the OIG's strategic goal and related objectives that will guide our oversight efforts in the area of financial management.

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

Audit Objectives:

- Manage the conduct of the annual Consolidated Financial Statements audit which, starting in FY 2000, will be performed under contract with the OIG responsible for administering the contract, issuing the final audit opinion, reporting on internal controls, and reporting on compliance with laws and regulations.

- Evaluate the effectiveness and efficiency of VA's financial organizational structure and the potential for improving services and better controlling costs through streamlining and restructuring efforts.

- Evaluate financial operations at all levels of VA and related internal controls over payments, debt collection, payroll, and performance measurement integrity and accuracy; and for safeguarding assets and preventing and detecting fraud.

- Evaluate and monitor implementation of VA's key financial management systems - Core Financial Logistics System (VA's replacement financial system, currently under development with implementation planned for FY 2001 - 2002 timeframe), HRLINK$, and Electronic Data Interchange (used in processing purchase orders and payments with vendors).

- Evaluate VHA's medical care revenue collection from non-appropriated sources.

- Evaluate VBA's accountability and stewardship for the delivery of benefits through the compensation, pension, education, and housing credit assistance systems.

- Evaluate VA compliance with requirements of the Clinger-Cohen Act, the Government Performance and Results Act, the Government Management Reform Act, and the Federal Financial Managers Integrity Act.

Healthcare Inspection Objective:

- Assist in the OIG evaluation of new financial systems, particularly the degree to which they influence the quality and value of health care services through decisions about sharing agreements, fee-basis care or similar approaches.

Investigation Objectives:

- Assist in the assessment of new financial systems, particularly the degree to which they influence the likelihood of VA suffering financial crimes.

- Provide advice on the designs, flags and trip-wires most often employed in financial systems to prevent financial crimes.

- Aggressively pursue financial crimes committed against VA programs.

STRATEGY

The OIG will determine whether VA's financial management systems are performing efficiently and effectively; meeting the requirements of accountability and stewardship; and providing VA managers, the Office of Management and Budget, and Congress with sound information for good decision making. Each year, the OIG will contract with a qualified independent public accounting firm to conduct the audit of VA's Consolidated Financial Statements. The OIG will monitor and supervise the contract.

The OIG will also conduct a program of national audits, program evaluations, and reviews of VA medical centers and regional offices to review financial operations at all levels. These products will focus on internal controls over payments, debt collection, payroll, and performance measurement integrity and accuracy.

Some of the payment processing control issues we will focus on include: credit card use; cash controls (including treasury reconciliation, suspense

and clearing accounts, agent cashier and imprest controls); duplicate payments; third party checks; fee basis medical care payments; out-of-system payments; electronic fund transfers; and, unliquidated obligations.

Debt management and collection control issues will include benefit program receivables and related waivers or compromises (compensation & pension, education, and loan guaranty); medical care collections and other medical program receivables (tort claims and co-pays); vendor receivables and offsets; waivers and compromises; write-offs; intra-agency and appropriation reimbursements; inter-agency reimbursements; and, recovery of advances.

Payroll control issues will include the Federal Employees Compensation Act (FECA) program; out-of-system payments; fictitious employees; payroll deductions (Federal Employees Retirement System, Thrift Savings Plans, and health and life insurance); special pay; premium pay; overtime; year-end salary accruals; and, payments for personal services. Evaluations of controls for safeguarding assets will include control of supply inventories, non-expendable equipment controls and write-offs, and real property.

Audits will be conducted of VA's capital investment policy to assess compliance with the Government Performance and Results Act and the Clinger-Cohen Act. The process will be evaluated to determine whether capital investment proposals are accurately tied to program plans and strategic program goals. These audits will also ensure that the VA's investment portfolio of capital investments maximizes return at an acceptable level and sets appropriate investment priorities.

PERFORMANCE MEASURES

Audit Measures:

- Number of Strategic Objectives Met
- Number of National Audits Completed
- Systemic Improvements Achieved
- Timely completion of contracted audit of VA's Consolidated Financial Statements
- Customer Satisfaction Surveys

Healthcare Inspection Measures:

- Meeting the Strategic Objective
- Contributions to OIG Reports Issued
- Customer Satisfaction Surveys

Investigation Measures:

- Number of Strategic Objectives Met
- Number of Proactive Investigations
- Number of Criminal Cases Closed
- Number of Arrests, Indictments and Convictions
- Reported Monetary Benefits
- Number of Administrative Investigations Completed
- Number of Administrative Actions Taken
- Number of Financial Crime Awareness Briefings
- Customer Satisfaction Surveys

IMPACT

The OIG's efforts will help ensure that managers at all organizational levels in VA receive timely, accurate financial information for assessment of program performance and management decision making. We will assist VA management in performing their stewardship function and safeguarding VA assets and resources from fraud or other misuse. Our reports will provide Congress and the public with accurate, reliable reporting on the cost of VA programs.

The development of sound financial controls will enable VA to increase collections on debts, recognize the cost of doing business, and minimize improper or inappropriate expenditures. Secure financial management systems will help minimize the risk of unauthorized individuals (inside or outside VA) inappropriately accessing personal or financial data in VA systems. Streamlining the financial organizational structure throughout VA will have significant potential for monetary benefits through consolidation and elimination of redundant operations.

Development and implementation of a state-of-the-art core financial and logistics system will indirectly enhance service to veterans and other customers. It will also decrease costs by eliminating inefficient systems while providing more accurate and timely information.

CHAPTER VI
STRATEGIC GOAL # 4
PROCUREMENT PRACTICES

STRATEGIC ASSESSMENT

VA spends over $5.1 billion annually for supplies, services, construction, and equipment. The VA Office of Acquisition and Materiel Management is responsible for national contracting and overseeing the acquisition, storage, and distribution of supplies, services, and equipment used by VA facilities.

A major challenge facing VA is to employ acquisition strategies that can leverage VA's full purchasing power to achieve the maximum economies of scale possible. VA must also ensure that contracts and other arrangements for the acquisition of goods and services are properly negotiated and reasonably priced, and that adequate levels of medical supplies, equipment, pharmaceuticals, and other supply inventories are on hand on a daily basis to satisfy demand. Inventories above those levels should be avoided so funds that could be used to meet other needs are not tied up in excess inventories.

VA must continue efforts to implement and automate purchasing activities, while capturing financial and performance information that provides an improved ability to track procurements for consolidating and standardizing purchases to gain pricing and quality enhancements. VA also needs to maintain an effective strategy to identify construction needs throughout the health care system, and to procure land to expand the cemetery system in response to increasing needs.

Over the past 6 years, legislation has been enacted that dramatically changed Government procurement. In 1994 Congress passed the Federal Acquisition Streamlining Act (FASA) and in 1996 passed the Federal Acquisition Reform Act (FARA), both of which changed Government procurement. Also in 1996, Congress passed the Veterans' Health Care Eligibility Reform Act, which contains provisions that allowed VA to further streamline the procurement of health care resources and expanded VA's authority to enter into sharing agreements to buy and sell health care resources.

Various reviews conducted over the past few years have shown certain areas of vulnerability in procurement programs. One of the most significant vulnerabilities is in the use of government credit cards. One of the initiatives of FASA and FARA was to simplify the purchase of commercial items in both the ordering and payment processes. One of the means used to achieve this was the decentralized use of credit cards at VA facilities. Recognizing the risks associated with decentralizing purchasing activities, VA established internal controls to monitor the use of the cards to prevent fraud and abuse. However, investigations and other OIG reviews conducted since the implementation of the credit card program have identified instances where these controls were not implemented and, thus, not effective. Thus far, we have shown that competitive procedures, including basic market research, price negotiation and determinations of price reasonableness, are not being followed and, as a result, VA has paid higher prices for commercial items. A challenge for the OIG is to explore the use of credit cards on a VA-wide basis to determine the extent and impact of the problem and to develop viable systemic solutions. Analysis is also needed to determine whether the use of credit cards has actually streamlined the procurement process and, if so, to what extent and at what cost.

Initial OIG oversight efforts indicate that credit card usage has affected the VA's national procurement programs including the Federal Supply Schedule (FSS). For example, in reviewing credit card purchases, we have identified large dollar open-market purchases from sole source vendors for which there is no evidence that required competitive procedures were followed. Pre- and post-award audit work has shown that some contractors are refusing to enter into or place certain items on FSS contracts because they know they will be able to sell the items open market at much higher prices than the National Acquisition Center will demand.

A related issue to explore is the relationship between the efforts of VA's Office of Acquisition and Materiel Management in negotiating FSS and standardization contracts and the procurement practices of VHA, particularly at the medical center level. One of the goals of acquisition streamlining was to conserve resources by decreasing the duplication of efforts. Some medical centers have sought better pricing from vendors who already have FSS contracts. OIG pre-award audits have shown that this affects VA's ability to negotiate most favored customer pricing on FSS contracts and ends up penalizing those medical centers that have to buy off the FSS contracts.

Recently, VA began entering into prime vendor or distributor agreements for the distribution of medical/surgical supplies and equipment. An issue facing

VA is whether these agreements are resulting in higher prices. For example, in some cases, the distributor orders a VA requested item from a manufacturer who ships the item directly to the medical facility. The distributor is then paid a fee based on the cost of the item. As a result, VA pays more for the items than if they had competitively procured them directly from the manufacturer.

Public Law 104-262 expanded VA's ability to buy and sell services through sharing, and VA has fully implemented the provisions of the statute. A particular area of OIG concern involves the use of expanded sharing arrangements with affiliated medical schools, which are negotiated on a sole source basis. Our concerns include whether VA is paying reasonable prices for the services, and whether Federal conflict of interest statutes are being violated. A potentially serious problem with contracts or other agreements with affiliated medical schools is that VA physicians involved in the preparation of the solicitation and the administration of the contract may be affiliated with the medical school and receive some form of compensation from the school. This arrangement raises serious ethics issues, and the possibility of criminal violations.

Fraud and other illegal activities committed against VA's acquisition programs can amount to millions of dollars. Contracts and procurements are inherently vulnerable to fraud due to the large expenditures of funds associated with purchasing the items necessary for maintaining an agency as large and diverse as VA. For example, illegal activities such as bribery/kickbacks by employees and contractors doing business with VA could result in VA being defrauded out of large sums of money which can impact VA's ability to provide the necessary care to veterans and their families.

Following is the OIG's strategic goal and related objectives that will guide our oversight efforts in the area of procurement.

Strategic Goal:	**Identify opportunities to enhance the effectiveness and efficiency of VA's acquisition program in meeting user needs and ensuring the best possible price, and help eliminate opportunities to commit fraud and other illegal acts in the procurement process by investigating and prosecuting criminal activity to the fullest extent of the law.**

Audit Objectives:

- Evaluate VA contracts to assure VA acquires supplies and services needed for efficient operations at fair prices and terms.

- Review Federal Supply Schedule (FSS) proposals and contracts to assess the accuracy, completeness and currency of pricing and sales data of supplies as required by the terms of VA contracts, and to detect problems such as defective pricing.

- Perform drug pricing reviews to assure compliance with the pricing provisions of Veterans Health Care Act of 1992, Public Law 102-585, that drug manufacturers calculate their federal ceiling prices and include all appropriate drugs on FSS contracts.

- Assess inventory management to provide improved assurances over justification, prioritization, accountability, and delivery of pharmaceuticals and other goods in VA's operations, such as consolidated mail out pharmacies.

- Examine acquisition and delivery support programs to provide assurances that supplies and services are being provided to VA operational components, such as medical centers and newly established Community-Based Outpatient Clinics, to ensure user needs are met effectively and efficiently.

- Evaluate construction projects and maintenance of medical facilities to ensure projects are completed on schedule, at reasonable cost, and provide a safe, healthy environment for patients, beneficiaries, visitors and employees.

- Review credit card purchases to determine whether cardholders are complying with applicable acquisition policies and regulations requiring competition, price reasonableness, and simplified acquisition procedures.

- Review open market, or non-contract, purchases at individual medical centers to determine whether comparable items are on contract at a cheaper price.

- Determine whether vendors with large dollar sales to VA either have refused to enter into FSS contracts, or if they have an FSS contract, have

refused to place items on contract because of the more lucrative open market purchases being made by some medical centers.

- Determine whether items sold to VA were made in the United States or a designated country under the Trade Agreements Act.

- Review medical/surgical prime vendor agreements to determine whether they are cost effective.

- Review sole source contracts for services with affiliated medical schools to determine price reasonableness and whether VA employees affiliated with the medical school who were involved in the preparation of the solicitation and the award or the administration of the contract were in compliance with conflict of interest statutes.

Healthcare Inspection Objective:

- Review quality of care issues related to programs such as prime vendor agreements, formularies, sole source contracts, fee basis services and similar approaches to obtaining medical care services.

Investigation Objectives:

- Ensure that crimes associated with VA procurement programs and operations are investigated in a timely manner and those individuals responsible are referred for prosecution or appropriate administrative action.

- Investigate procurement-related fraud and ensure that any systemic vulnerability to fraud in VA's contracting process is addressed and corrected.

- Initiate a proactive nationwide investigative effort aimed at identifying and prosecuting fraud cases associated with the purchase card program.

- Work with the OIG Contract Review and Evaluation Division to identify potential procurement fraud.

- Participate in joint criminal and civil investigations of companies and individuals that commit procurement fraud involving multiple Federal agencies, one of which being VA.

STRATEGY

As VA's procurement processes evolve in response to changing legislation and requirements, the OIG's strategy will be to promote efficient and economical policies and procedures. In doing so, the OIG will determine whether VA procurement activities take advantage of VA's full purchasing power to achieve the best possible prices while meeting users' demand needs. The OIG will collect and analyze procurement data to identify systemic and individual procurement issues related to pricing and quality that need management attention.

Programs, operations and internal controls will be scrutinized to provide the necessary assurances that VA procurement is sufficiently protected from fraud, waste and abuse. This will be achieved through a coordinated effort involving audit, health care inspections and investigative expertise. The OIG will identify best practices and opportunities for revising policies, procedures and practices, streamlining programs, achieving savings and other improvements impacting the management and administration of VA procurement.

The OIG will review VA's management of acquisition program operations and assess program results of major procurement initiatives, such as the use of consolidated buying mechanisms, product standardization, electronic data interchange, and supply fund management. Reviews of Federal Supply Schedule (FSS) proposals and contracts will be performed to assess the accuracy, completeness, and currency of pricing and sales data of supplies as required by the terms of VA contracts. Drug pricing reviews will be performed to assure drug manufacturers calculated their Federal ceiling prices and included all appropriate drugs on FSS contracts, as mandated.

Regularly scheduled Combined Assessment Program (CAP) reviews at individual VA facilities will focus on purchase cards, printing practices, inventory management, drug accountability, service contracts, and enhanced use leases. These reviews, done in concert with national audits and proactive investigative efforts, will contribute to assessing and improving VA procurement.

Another aspect of our strategy involves addressing allegations reported to the OIG Hotline pertaining to procurement activities, such as allegations involving inappropriate sole source contracting or defective pricing. The OIG will trend these cases in order to develop leads for proactive efforts into high-risk areas. The results of audits, investigations, CAP reviews and Hotline

cases will be conveyed in written reports that are objective and timely, and provide VA management with recommendations aimed at improving the price and quality of VA procurements.

Through liaison and by conducting fraud integrity awareness briefings, the OIG will help ensure that VA employees are aware of the types of crimes occurring and the proper procedures for referring allegations of fraud involving VA procurement to the OIG. The OIG will continue to develop proactive initiatives to identify fraud in the use of purchase cards and other procurement processes. We will aggressively pursue crimes against VA and seek prosecution to the fullest extent of the law. We will also work to prevent fraud by identifying program weaknesses and making recommendations for system corrections that will help eliminate opportunities to commit fraud and other illegal acts in the procurement process.

PERFORMANCE MEASURES:

Audit Measures:

- Number of Strategic Objectives Met
- Number of National Audits Completed
- Systemic Improvements Achieved
- Customer Satisfaction Surveys

Healthcare Inspection Measures:

- Meeting the Strategic Objective
- Contributions to OIG Reports Issued
- Customer Satisfaction Surveys

Investigation Measures:

- Number of Strategic Objectives Met
- Number of Proactive Investigations
- Number of Criminal Cases Closed
- Number of Arrests, Indictments and Convictions
- Reported Monetary Benefits
- Number of Administrative Investigations Completed
- Number of Administrative Actions Taken
- Number of Fraud Awareness Briefings
- Customer Satisfaction Surveys

IMPACT

Conducting audits, investigations and reviews of procurement activities can identify and deter fraud, waste and other abuses that may exist, and assist management in promoting integrity in VA program operations. Significant cost recoveries have been collected by the VA based on the results of OIG contract and drug pricing reviews, and these recoveries are expected to continue in the future. Work addressing inventory management issues will further improve accountability over the supplies and reduce the carrying cost associated with maintaining excessive inventories. Cost savings will be achieved by leveraging and consolidating VA's purchasing power, and VA will receive timely delivery of products and services at the lowest prices. Through successful criminal and civil prosecutions of violations of the laws, rules, and regulations governing VA procurement programs, we will improve the deterrence of fraud. We will also refer findings of fraud and other illegal activities affecting the responsibility of contractors to VA for suspension/ debarment consideration.

CHAPTER VII
STRATEGIC GOAL # 5
INFORMATION MANAGEMENT

STRATEGIC ASSESSMENT

VA faces a major challenge to leverage the full potential of information technology (IT), particularly the Internet and Intranet opportunities, to improve performance, cut costs, and enhance access and responsiveness to employees, veterans, other stakeholders and the public. As VA moves to improve its IT decisions and investment control processes, there are challenges in the area of information collection; performance measurement; paperwork reduction; statistical activities; records management activities; privacy and security of information; data integration; sharing and dissemination of information; and the acquisition and use of IT. VA must continue to enhance its capital planning processes for IT to ensure adequate oversight and management of its IT resources as it selects, controls, and evaluates the results of all its major IT investments.

Information technology is critical to controlling costs and improving the performance of VA programs. To this end, VA administrations have restructured organizational authority and accountability to empower managers and create an environment conducive to innovation and efficiency. However, an unintended outcome of the empowerment process has been fragmentation in planning IT systems, procurement of IT hardware and software, and diminished visibility and oversight of IT matters. VA still faces significant challenges in that many of its IRM systems remain independent and serve limited, parochial interests. VA-wide, these areas have suffered from multimillion-dollar cost overruns, schedule slippage and disappointing results.

High-risk areas such as systems development, operations and maintenance, security, and the management of VA IT infrastructure are priority areas needing increased oversight. The potential vulnerability of Federal information systems cannot be underestimated. Presently, VA systems are not adequately protected from unauthorized access. Risks exist such as the potential disclosure of sensitive data, loss of assets due to fraud, and

disruption of critical operations. Security over VA IT resources needs to assure that only authorized users access VA resources and only authorized use is made of VA resources.

VA is faced with the formidable challenge of improving the physical and electronic security over its IT resources. VA requires automated processing of transactions valued at over $40 billion annually, and maintenance of over 40 million sensitive veteran records. Combined VA IT expenditures total over $600 million annually. While sharing of data and technology among organizations has made service better for veterans it has increased security risks and the number of issues requiring oversight. Multiple architectures and complex mission-specific systems at several large data processing centers, and about 200 smaller data processing facilities, make VA's overall IT system a high-risk area.

Providing adequate security to protect IT resources has been an ongoing concern within VA. For example, we have reported that:

- Comprehensive security programs were not in place at data centers.
- Risk assessments were not developed and maintained.
- Center-wide security plans had not been developed.
- Systems were not certified as secure.
- Numerous physical and electronic security controls needed to be implemented.

VA needs to manage its information systems more effectively. Specifically, VA has yet to link its processes for selecting, controlling, and evaluating information technology investments to any specific performance measures in its annual plan. VA also lacks adequate control and oversight of access to its computer systems.

VA has numerous automated data collection systems that are needed to support GPRA objectives. However, OIG review of these systems has found erroneous data in many of the systems, including those involved in medical care, benefits and education programs.

VA has established a goal to implement a One VA information technology framework that supports the integration of information across business lines and that provides a source of consistent, reliable, accurate and secure information to veterans and their families, employees and stakeholders. Achieving this is a significant challenge for VA, where independent systems span all three Administrations. Developing a coordinated and integrated

environment for information technology under a One VA framework poses several new and difficult challenges for VA over the next few years. A key challenge for the OIG as VA works to achieve this goal is to review IT capital investment proposals to ensure that only well-planned and coordinated efforts are approved for funding. In unison with IT capital planning improvements, VA needs to strengthen its staffs' capabilities to manage information resources and to leverage IT enhancements while dealing with emerging technology issues.

Information systems are integral to almost every aspect of VA's operations, and the efficiency and effectiveness of VA is dependent upon the future use of these systems. Reliable automated systems that provide accurate and current data on results of VA operations are necessary for VA decision-makers, service providers and caregivers to meet mission requirements. For example, accurate and current information is critical to the effectiveness of financial management, including oversight of accounting and financial management systems. VA computer systems annually process, account for, and disburse: $25 billion in compensation, pension, and education benefits to 3.8 million beneficiaries; $21 billion to provide medical care to 2.9 million beneficiaries; $62 million in construction expenses; and over $1 billion in general and miscellaneous operating expenses. Approximately 80 accounting systems/applications are in use, and 61 systems have been classified as sensitive according to OMB Circular A-130.

Information systems security was identified as a material weakness in FY 1998. VA's assets and financial data are vulnerable to error and fraud because of weaknesses in information security management, access to controls and monitoring, and physical access controls. VA has targeted correction of these concerns by FY 2003. As such, information security and planning will be at the forefront of the OIG oversight efforts as VA works toward achieving a fully integrated IT environment. In doing so, the OIG will focus on a comprehensive approach to managing risk through continuous assessment, policy development, workforce education, security automation, and management and oversight.

Critical legislative reform was designed to strengthen Federal agencies' executive leadership on information management and to help ensure agencies institute sound capital investment decision for maximizing potential benefits from information resources acquisitions and systems. Such reforms include the Presidential Decision Directive 63 (Critical Infrastructure Protection), the Paperwork Reduction Act of 1995, and the Clinger-Cohen Act of 1996. These reforms direct agencies to implement a framework of modern

technology management incorporating best practices of public and private sector organizations to improve performance, provide protection to strategic resources, and meet strategic goals. In addition, the Privacy Act, Computer Matching Act, and others place requirements on the OIG to perform tests and evaluations of IT systems and programs.

Following is the OIG's strategic goal and related objectives that will guide our oversight effort in the area of information resources management.

Strategic Goal: **Determine if VA's information systems are adequately protected and provide accurate, complete, and timely information in order to improve performance, cut costs, and enhance customer service; and investigate fraud and other computer related crimes against VA.**

Audit Objectives:

- Assess VA's efforts to address information security control weaknesses and to establish a comprehensive integrated security management program.
- Evaluate acquisition and implementation priorities for effectively acquiring, designing and delivering IT, including telecommunication products and services.
- Assess the effectiveness of national and local acquisition strategies for acquiring IT resources and services.
- Evaluate the performance of selected mission critical IT applications to assess the effectiveness in meeting VA user needs.
- Evaluate whether VA IT integrates VA programs and operations to better serve the veteran and beneficiaries.
- Evaluate whether information stored, processed, or transmitted by VA systems is protected from inappropriate disclosure, manipulation, or alteration.

- Determine whether information used to make business decisions is accurate, timely, and complete.

Healthcare Inspection Objective:

- Assess the impact of VA IT on the quality, access, risk, safety and value of health care services to veterans.

Investigation Objectives:

- Identify fraudulent and other criminal activities associated with the acquisition and maintenance of IT supplies and services.

- Identify theft and other inappropriate losses of IT resources, and unlawful access and use of information systems, data, and IT resources.

- Ensure that crimes occurring in VA's computer systems are investigated in a timely manner and those individuals responsible are referred to the Department of Justice or other appropriate law enforcement authority for prosecution and/or to VA for administrative action.

STRATEGY

The OIG will provide oversight of VA's management of information resources by conducting a program of planned audits aimed at addressing high risk areas of security, system development and maintenance, data reliability and IT acquisitions. These audits will examine performance indicators such as customer satisfaction, achievement of strategic goals, and cost effectiveness and impact of IT investments.

Coverage of planned audit work will be augmented by including coverage of significant IT risk areas as part of the OIG's Combined Assessment Program (CAP). This program has been designed to cover VA operational components including Medical Centers and Benefits Regional Offices and provide further assurance that security protections required by VA policy are put into action at the field level.

We will continue to review VA's Government Performance and Results Act (GPRA) performance measures to help assure the validity, reliability and integrity of the reported data. As part of the annual audit of VA's Consolidated Financial Statements, the OIG will continue to assess the adequacy and integrity of VA information systems. Specifically, our audit will

assess entity-wide security program planning and management, access controls, application software development, systems software, segregation of duties, and continuity of service. Information integration throughout VA will also be assessed to determine if such integration is improving service delivery to veterans and cutting costs.

Technology has radically transformed the work environment for all Federal employees. With the fast pace of current technology, there is a need to recognize that everything done electronically is vulnerable to fraud. From medical records to applications for loans or benefits, VA is evolving into a computer-based organization. Programs, operations and internal controls will be assessed to provide the necessary assurances that VA is better protected from security threats and other risks. We will strive to prevent fraud by identifying program weaknesses and making recommendations to enhance internal controls associated with IT systems.

Dealing effectively with computer related crimes affecting VA requires the involvement of individuals with expertise and knowledge of computer systems and networks. To this end, the OIG will promote communication and work with the VA CIO Council, Information Security Officers, Information Security Working Group, and other Offices of Inspectors General and law enforcement agencies. The recently established OIG Computer Crimes and Forensics Program will greatly enhance our effort to ensure that computer related crimes occurring in VA will be investigated in a timely manner and those individuals responsible are referred for prosecution and/or for appropriate administrative action.

Further, the OIG has recently implemented a program for its professional audit staff aimed at providing them the training, experience, and skills needed to achieve the designation of Certified Information Systems Auditor. This expertise is central to fulfilling our oversight responsibilities in this highly technical field.

Through liaison and conducting fraud integrity awareness briefings, the OIG will ensure that VA officials are aware of the types of crimes occurring and the proper procedures for referring allegations of fraud involving VA computer systems to the OIG. The OIG will provide VA with timely response to incidents involving computer network intrusion and crimes committed electronically, and seek prosecution against any unlawful internal and external network perpetrators. Working with other law enforcement entities, the OIG will help develop and maintain a government-wide database to categorize cyber-similarities between IT threats to help develop leads and better investigate egregious computer crime violations.

PERFORMANCE MEASURES

Audit Measures:

- Number of Strategic Objectives Met
- Number of National Audits Completed
- Systemic Improvements Achieved
- Customer Satisfaction Surveys

Healthcare Inspection Measures:

- Meeting Strategic Objective
- Contributions to OIG Reports Issued
- Evaluations on health care related technologies

Investigation Measures:

- Number of Strategic Objectives Met
- Number of Proactive Investigations
- Number of Criminal Cases Closed
- Number of Arrests, Indictments and Convictions
- Reported Monetary Benefits
- Number of Administrative Investigations Completed
- Number of Administrative Actions Taken
- Number of Fraud Awareness Briefings
- Customer Satisfaction Surveys

IMPACT

Conducting audits, investigations and reviews of IT acquisitions, information system development projects, data reliability, and security will identify areas of significant risk and vulnerabilities and help VA protect its operations and information. Cost savings will be achieved through better management of IT acquisitions as significant project cost overruns, project slippages and poor returns on IT investments are avoided. Audits and reviews will help identify and address underlying management problems that impede system development and operations, and help to identify and prevent expending Agency funds to maintain obsolete information systems unnecessarily. Completing GPRA related performance measure assessments would help assure the validity, reliability, and integrity of VA data. OIG oversight will also provide assurance that information stored, processed, or transmitted using VA systems is protected from inappropriate disclosure, manipulation, or

alteration. OIG oversight will improve the integrity of VA systems and help deter and prevent fraud and other computer related crimes against VA IT systems.

CHAPTER VIII
EXTERNAL FACTORS

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

Acceptance of OIG Results and Recommendations

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

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

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

Loss of Expertise

As the baby-boomer generation matures, attrition of staff due to retirement is expected to be a major concern throughout government. With this attrition comes a loss of corporate knowledge and expertise. While we have focused on succession planning and provided training and other opportunities to develop expertise and knowledge, several years of declining resources places us at a disadvantage. Recruiting highly qualified employees, especially with information technology expertise, is becoming increasingly difficult due to competition from the private sector, which is being fueled by a strong economy.

Proactive versus Reactive Work

During the past several years, approximately 60 percent of the OIG staff available for operational activities were assigned to reactive work resulting from requests for assistance from Congress and VA management. In addition, a substantial amount of Investigation and Healthcare Inspection resources are devoted to responding to allegations received by the OIG Hotline. Within Audit, resources are also diverted to reactive work or to fulfilling mandated work, such as the annual audit of VA's consolidated financial statement. Of particular concern is the possibility that additional mandates will be established without a provision for additional staff to perform the work.

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

Legislation

Passage of new legislation could impact and/or change the programs or conditions that VA currently manages. For example, legislation making veterans' dependents eligible to receive VA medical care, or the granting of service-connection to veterans for tobacco related

conditions would dramatically increase the number of individuals eligible to receive health care and VA benefits. This would create new demands and challenges for VA in terms of facilities, staffing, funding needs, etc., which in turn would cause us to reevaluate our goals and objectives in terms of what would be the most pressing issues facing VA.

Unforeseen Situations

Hostile, sustained actions of conflict by a foreign country against the military of the United States could create a rapid increase in military personnel injuries, which requires refocusing VA medical centers' mission to respond to that need.

Unpredicted outcomes such as the long-term health effects of military service in the Persian Gulf or the number and timing of cancer claims filed by Vietnam veterans, could increase demand for VA medical care and benefit resources.

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

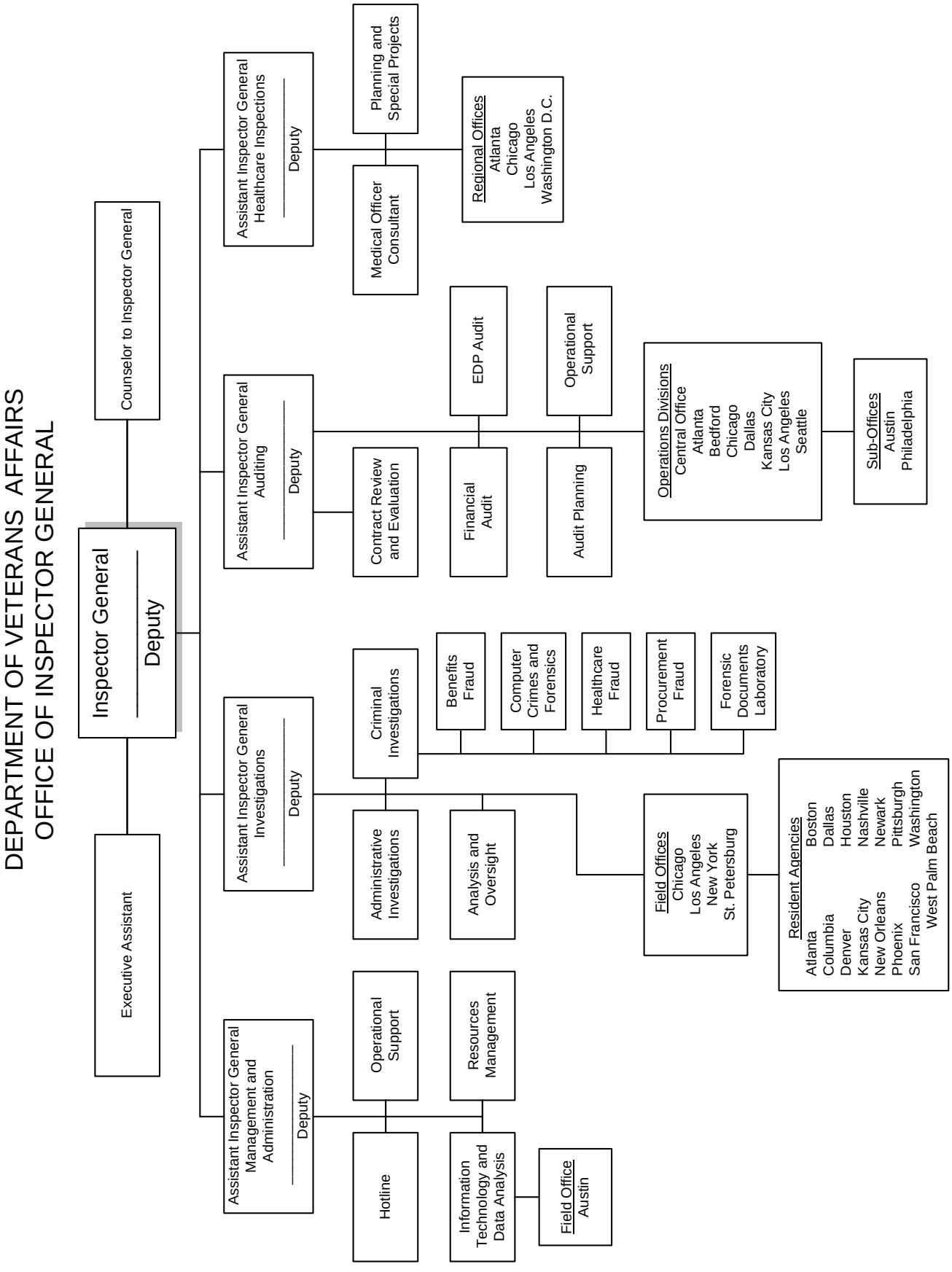
Information Technology

The private sector has achieved significant efficiencies and made significant improvements in how they deliver services through advances in information technology. As VA continues to adopt more advanced information technology to improve VA operations and service delivery, concerns about hackers, terrorists, and thieves gaining access to VA systems and "previously thought to be secure" data in today's electronic-high tech world will create new challenges and new priorities for VA and the OIG.

To mitigate the impact these factors can have on the success in achieving our goals, we will strive to ensure high quality work that will withstand administrative and legal scrutiny. We always work to maintain our independence and issue work products that are thorough and objective. Further, we will work with our customers to provide them with work products that are important and useful to them. We will collaborate on issues and try to develop recommendations that are meaningful, viable and supported by

management as real time solutions to improving VA activities. If external factors contribute to delays in achieving our strategic goals and objectives, these conditions will be communicated in our annual performance reports.

APPENDIX A
VA OIG ORGANIZATION CHART


DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
Inspector General
Deputy
Counselor to Inspector General
Executive Assistant
Assistant Inspector General Healthcare Inspections
Deputy
Planning and Special Projects
Medical Officer Consultant
Regional Offices
Atlanta
Chicago
Los Angeles
Washington D.C.
Assistant Inspector General Auditing
Deputy
Contract Review and Evaluation
EDP Audit
Financial Audit
Operational Support
Audit Planning
Operations Divisions
Central Office
Atlanta
Bedford
Chicago
Dallas
Kansas City
Los Angeles
Seattle
Sub-Offices
Austin
Philadelphia
Assistant Inspector General Investigations
Deputy
Criminal Investigations
Benefits Fraud
Computer Crimes and Forensics
Healthcare Fraud
Procurement Fraud
Forensic Documents Laboratory
Administrative Investigations
Analysis and Oversight
Field Offices
Chicago
Los Angeles
New York
St. Petersburg
Resident Agencies
Atlanta
Boston
Columbia
Dallas
Denver
Houston
Kansas City
Nashville
New Orleans
Newark
Phoenix
Pittsburgh
San Francisco
Washington
West Palm Beach
Assistant Inspector General Management and Administration
Deputy
Operational Support
Resources Management
Hotline
Information Technology and Data Analysis
Field Office
Austin

APPENDIX B
CUSTOMER SATISFACTION SURVEY FORMS

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

Office of Investigations
Customer Survey

VAOIG file #

Subject(s):

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

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

   1 2 3 4 5 N/A

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

   1 2 3 4 5 N/A

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

   1 2 3 4 5 N/A

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

   a. ___the quality of the investigation?

   b. ___the lack of evidence to substantiate the charge(s)?

   c. ___the availability of administrative remedies?

   d. ___other reasons (please explain on reverse)?

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

   1 2 3 4 5

Completed by:_____
_____
_____

Return form to: Department of Veterans Affairs
Office of Inspector General (50)
Washington, D.C. 20420

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
QUALITY SURVEY

Report Number_____Report Date:

Report Title:

Respondent's Name, Title and Location:

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

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

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
QUALITY SURVEY

QUALITY PROGRAM ASSISTANCE (QPA) REVIEW (COMPONENT OF A COMBINED ASSESSMENT PROGRAM (CAP) REVIEW

OHI Report Number:

Report Date:

Report Title:

OHI is charged with overseeing VHA's programs. Each year, with input from VHA, OHI selects a number of nationwide VHA programs to review proactively. These reviews are intended to be peer inspections of key VHA programs. Our goal is to provide VHA managers with ideas and suggestions for further program development and refinement. Please assist us in determining to what extent we met these goals.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Agree	Not Applicable
The goals of the review, as stated above, were important to the VHA.	5	4	3	2	1	N/A
The purpose, scope and methodology of the review were explained fully to VHA managers during the "Entrance Conference."	5	4	3	2	1	N/A
OHI inspectors kept VHA managers apprised of the inspection process.	5	4	3	2	1	N/A
The review results were discussed fully with VHA managers during the "Exit Conference."	5	4	3	2	1	N/A
OHI inspectors conducted themselves professionally and courteously.	5	4	3	2	1	N/A
The report was written clearly and organized logically.	5	4	3	2	1	N/A
The report contained sufficient information to support the findings.	5	4	3	2	1	N/A
The recommendations were reasonable, achievable, and consistent with the findings.	5	4	3	2	1	N/A
VHA's comments to the draft report were considered and appropriately incorporated into the final report.	5	4	3	2	1	N/A
The report was provided to VHA managers in a timely manner.	5	4	3	2	1	N/A
The proactive program review provided useful insights into this VHA program.	5	4	3	2	1	N/A

We would appreciate your suggestions for improving future program evaluations:

Respondent's Name:_____

Title:_____

Location:_____

Contact Telephone Number:_____

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
QUALITY SURVEY

HOTLINE CASE REVIEW

OHI Report Number:

Report Date:

Report Title:

OHI is frequently called upon to review "hotline" allegations. Many times hotline inspection requests come directly from the Secretary of Veterans Affairs or Congress. Hotline inspections generally focus on issues that involve activities in one VA medical center, and require the exploration and evaluation of practitioner performance, or system-related issues associated with treating individual patients. Our goal is to address objectively and fairly all allegations and concerns. Please assist us in determining to what extent we have met these goals.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable
The inspector(s) clearly communicated the goals of this inspection.	5	4	3	2	1	N/A
The inspector(s) entrance briefing prepared you for the process that ensued.	5	4	3	2	1	N/A
Inspector(s) discussed preliminary findings during the exit briefing.	5	4	3	2	1	N/A
The inspector(s) kept you apprised of the inspection's progress.	5	4	3	2	1	N/A
The inspector(s) acted professionally and courteously.	5	4	3	2	1	N/A
Inspector(s) conducted their work with minimal disruption to staff.	5	4	3	2	1	N/A
Inspection findings were sound, and supported by sufficient factual information.	5	4	3	2	1	N/A
Recommendations were relevant, realistic and achievable.	5	4	3	2	1	N/A
Inspectors considered your comments and appropriately incorporated them into the final report.	5	4	3	2	1	N/A
The inspection brought closure to the complainant's allegations.	5	4	3	2	1	N/A

We would appreciate your suggestions for improving future inspections

Cover photo of
Iwo Jima Memorial
Arlington, VA by
Joseph M. Vallowe, Esq.
VA OIG, Washington, DC

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OCTOBER 2000