Major Management Challenges Identified by the OIG

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

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

- ***Estimated resolution timeframe (fiscal year)*** to resolve the challenge
- ***Responsible Agency Official*** for each challenge area
- ***Completed 2011 milestones*** in response to the challenges identified by the OIG
- ***Planned 2012 milestones*** along with ***estimated completion quarter***

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

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Department of Veterans Affairs

Memorandum

Date: July 15, 2011

From: Inspector General (50)

Subj: 2011 Performance and Accountability Report

To: Secretary of Veterans Affairs (00)

1. Please see the attached Office of Inspector General (OIG) update regarding VA's most serious management challenges for inclusion in the 2011 Performance and Accountability Report (PAR). Our staff worked with VA staff to arrange publication of the full OIG report on major management challenges in the PAR.

2. OIG is submitting this statement to the Department pursuant to Section 3516 of Title 31, United States Code. The law states that the Department may comment on, but may not modify, the OIG statement. Please ensure the Department provides all suggested changes to OIG for review prior to incorporation into the PAR.

3. On behalf of OIG staff, I am appreciative of the level of support and cooperation we have received from the Department as we work to improve VA. We especially appreciate the support you and the Deputy Secretary have exhibited as we work together to address the major challenges facing VA. We look forward to working with both of you to complete the implementation of key OIG recommendations in the future.

George J. Opfer

GEORGE J. OPFER

Attachment

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

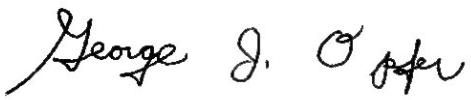
FOREWORD

Our Nation depends on VA to care for the men and women who have sacrificed so much to protect our freedoms. These service members made a commitment to protect this Nation, and VA must continue to honor its commitment to care for these heroes and their dependents—in a manner that is as effective and efficient as possible. VA health care and benefits delivery must be provided in a way that dually meets the needs of today's and yesterday's Veterans. It is vital that VA health care and benefits delivery work in tandem with support services like financial management, procurement practices, and information management to be capable and useful to the Veterans who turn to VA for the benefits they have earned.

Office of Inspector General (OIG) audits, inspections, investigations, and reviews recommend improvements in VA programs and operations, and act to deter criminal activity, waste, fraud, and abuse in order to help VA become the best-managed service delivery organization in Government. Each year, pursuant to Section 3516 of Title 31, United States Code, OIG provides VA with an update summarizing the most serious management and performance challenges identified by OIG work and other relevant Government reports, as well as an assessment of the Department's progress in addressing those challenges.

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

OIG will continue to work with VA to address these identified issues and to ensure that the Department will provide the best possible service to the Nation's Veterans and their dependents.



GEORGE J. OPFER
Inspector General

MAJOR MANAGEMENT CHALLENGES

The Office of Inspector General (OIG) identified the major management and performance challenges currently facing VA, that, if left uncorrected, have the potential to impede VA's ability to fulfill its program responsibilities and ensure the integrity of operations. While the Department has made much progress, there is still much to do to establish an effective and efficient organization. OIG remains committed to keeping decision makers informed of longstanding and emerging problems identified through our audits, inspections, investigations, and reviews so that the Department can take timely corrective actions. For the most part, these challenges are not amenable to simple, near-term resolution and can only be addressed by a concerted, persistent effort, resulting in progress over a long period of time.

To identify major challenges facing the Department, OIG examined previously issued audit and inspection reports where corrective actions have yet to be taken; assessed ongoing audits, inspections, investigations, and reviews to identify significant vulnerabilities; and analyzed new programs and activities that could pose significant challenges due to their range and complexity. In addition, OIG's strategic planning process is designed to identify and address the key issues facing VA. OIG focused on the key issues of health care delivery, benefits processing, financial management, procurement practices, and information management in its *2009–2015 OIG Strategic Plan*. The flexibility and long range vision in the OIG Strategic Plan are essential in a period of expanding need for VA programs and services. Although the Nation's newest and oldest Veterans both face a growing need for VA health care and benefits programs, many of the specific services they need differ, and all of them must be the best possible.

VA has identified transformational goals designed to transform the Department into a 21st century organization that is Veteran-centric, results-driven, and forward-looking. The stated focus of these goals is to ensure VA provides high-quality care and timely delivery of benefits to Veterans over their lifetimes. The Department has acknowledged that the transformation will require resources, commitment, and teamwork. OIG will keep management informed of any challenges identified during our audits, inspections, investigations, and reviews.

The following summaries present the most serious management challenges facing VA, grouped into critical areas: (1) Health Care Delivery, (2) Benefits Processing, (3) Financial Management, (4) Procurement Practices, and (5) Information Management. OIG also assesses the Department's progress in overcoming these challenges. While these issues guide our oversight efforts, OIG continually reassesses our goals and objectives to ensure that our focus remains timely and responsive to changing priorities.

OIG CHALLENGE #1: HEALTH CARE DELIVERY
-Strategic Overview-

For many years, the Veterans Health Administration (VHA) has been a national leader in the quality of care provided to patients when compared against other major U.S. health care providers. VHA's use of the electronic medical record, its National Patient Safety Program, and its commitment to data-driven metrics to improve the quality of care has sustained this high quality of medical care. VHA's action to provide the public access to extensive data sets on quality outcomes and process measures is a further step forward as a national leader in the delivery of health care. Additionally, VHA's action to determine each hospital's ability to handle complex surgical cases, give a rating, and then limit the procedures that can be performed at each class of facility is further evidence of its groundbreaking efforts to maintain and improve upon the quality of care that Veterans receive.

However, VHA faces particular challenges in managing its health care activities. The effectiveness of clinical care, budgeting, planning, and resource allocation are negatively affected due to the continued yearly uncertainty of the number of patients who will seek care from VA. Over the past 7 years, OIG has invested about 40 percent of its resources in overseeing the health care issues impacting our Nation's Veterans and has conducted reviews at all VA Medical Centers (VAMC) as well as national inspections and audits, issue-specific Hotline reviews, and criminal investigations. The paragraphs that follow highlight the issues most challenging to today's VHA.

OIG Sub-Challenge #1A: Quality of Care

VHA faces increased challenges in meeting the mental health needs of today's returning war Veterans. The high incidence of Post-Traumatic Stress Disorder (PTSD), depression, substance abuse, and military sexual trauma (MST) among today's Veterans challenge VHA to provide one standard of care across the country. This is especially impacted by the increase in the number of women Veterans. An OIG review of combat stress in women Veterans receiving VA health care and disability benefits found that, generally, female Veterans were more likely to use VA health care, to continue using VHA services even years after separating from active military service, and to use it more frequently than male Veterans. The study established that although female Veterans generally were more likely to be diagnosed with mental conditions, they generally were less likely than their male counterparts to be diagnosed with traumatic brain injury (TBI) and the specific mental condition of PTSD.

The patterns corroborated additional findings that higher proportions of female Veterans generally were awarded disability for mental health conditions other than PTSD, and a higher proportion of men were generally awarded disability for PTSD and TBI.

Although VHA has a high compliance with the goal of providing at-risk Veterans with suicide safety plans, VHA is challenged to ensure that coordination of care between VHA medical facilities and civilian and military facilities and providers for at-risk Veterans is improved. Deficits in the coordination of care for these high-risk patients may result in patient deaths.

VHA has demonstrated the ability to deliver a high quality of patient care as determined by standard measures of population health. However, OIG continues to note excessive variation in the quality of

care delivered. With the increasing number of Veterans receiving care at community-based outpatient clinics (CBOC), VA faces challenges in delivering quality care at CBOCs that are often distant from their parent facilities.

While CBOCs expand Veterans' access to care, they require increased oversight by VHA. An OIG audit of CBOC management oversight found that VHA lacks the means to evaluate CBOC performance at the national, regional, and local levels; ensure parent facilities provide adequate CBOC oversight; and identify health care gaps at VA and contractor-operated CBOCs. In addition, VHA lacks the management controls needed to ensure CBOCs provide Veterans consistent, quality care, further noting that CBOC Primary Care Management Module (PCMM) data, which VHA uses to make budgetary and resource management decisions, is inaccurate. Inaccurate PCMM data and problems in the completion of TBI and MST screenings at CBOCs demonstrate the need for VHA to establish CBOC-specific monitors to evaluate systemic problems and deviations from VHA's one standard of care. To address this challenge, VHA is in the process of taking action to improve the accuracy of PCMM data, monitor TBI and MST screenings, and establish a comprehensive CBOC performance monitoring system.

VHA recognizes the importance of safe and consistent reusable medical equipment (RME) practices, but continues to face problems despite efforts to comply fully with proper reprocessing procedures. Veterans seeking care at a VA facility should have assurance that any equipment they come in contact with will be properly cleaned and, if necessary, sterilized, within specifications promulgated by bodies advising on such processes. To do otherwise, at a minimum, exposes patients to unnecessary and unacceptable risk of infection. VA medical facilities have been identified as using improperly reprocessed RME in a number of instances. Specific causes of breakdowns include failure to follow manufacturer's instructions and failure to keep employees currently trained in all equipment cleaning and maintenance specifications. The task is additionally challenging because new medical product designs occur continuously, and new types of medical equipment are continually brought into the system. VA must ensure that processes are in place to ensure that Veterans' health is not placed at risk because of lax attention to detail and failure to adhere to commonly accepted standards of infection control.

VHA must also work to ensure Veterans' health is not compromised due to excessive radiation exposure during the course of receiving care at VA facilities. Although radiation is a common form of energy used to obtain clinical data, usually images of the body through procedures such as computed tomography (CT), fluoroscopy, and nuclear medicine studies, the cumulative dose of radiation that humans receive correlates with the risk of developing serious medical conditions. Despite that VHA disseminated information to hospital radiology departments in an effort to reduce CT dose variability, OIG has found no oversight of actual doses being delivered, no indication that patients or providers had data about cumulative radiation exposure available to them at the time of clinical decision making, and no evidence that patients were informed that CT scans may cause cancer. Moreover, for nearly 2 years, VHA has been developing, but has yet to publish, guidance regarding the use of fluoroscopy. VHA is challenged to ensure that Veterans' exposure to radiation is appropriate to the clinical circumstances and that the lifetime exposure dose to radiation is a factor in the selection of health care procedures that are appropriate for a patient's clinical condition.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Under Secretary for Health

Completed 2011 Milestones

VHA medical facilities, in collaboration with civilian and military facilities and providers, have improved suicide prevention practices for at-risk Veterans. For example:

- VHA Facility Suicide Prevention Coordinators now call community or military facilities and arrange for continuity at discharge if they become aware of an outside admission of a high risk patient.
- The National Suicide Prevention Lifeline consult processes require contacts be established with the Suicide Prevention Coordinator at a relevant VHA facility if a Veteran calls the lifeline.
- The identification of at-risk Veterans in patient records informs all providers at a VHA facility about a potential risk of suicide. This facilitates coordination of care if a Veteran seeks care outside of VHA.
- Each VHA facility is encouraged to develop communication strategies with local non-VHA facilities about suicide prevention involving Veterans.

VA addressed the mental health needs of today's returning war Veterans by using a multi-faceted approach. VA's Office of Mental Health Services provided sensitivity training to Women Veterans Coordinators on April 21, 2011, and this lesson, Military Sexual Trauma Sensitivity Training, was added to the Talent Management System on May 31, 2011.

VBA and the Under Secretary for Benefits brought a new focus on the processing of PTSD claims based on Military Sexual Trauma (MST).

- The Veterans Benefits Administration (VBA) incorporated sensitivity training into the 2011 National Training Curriculum mandatory training hours required for all claims processors. This mandatory curriculum includes a new MST training lesson created by VBA's Compensation Service and the *Military Sexual Trauma Sensitivity Training* lesson.
- In March 2011, signs were posted in all VBA regional offices to ensure that Veterans are aware of services and assistance provided by Women Veterans Coordinators. These coordinators case manage claims including assisting claimants in gathering the evidence necessary to decide their claims.
- In June 2011, VA's Under Secretary for Benefits issued a letter to all field personnel emphasizing the relaxed claims processing standards for MST claims.
- VBA's Compensation Service provided additional guidance in July 2011 instructing the field that corroborating evidence of a MST could be found on DD Form 2910, *Victim Reporting Preference Statement* and DD Form 2911, *Forensic Medical Report: Sexual Assault Examination* and similar forms.
- The Compensation Service drafted a new comprehensive training letter and plan for field personnel devoted to processing these claims.

VA Central Office officials now use data and other information about each CBOC's performance in the face-to-face quarterly reviews with each Veterans Integrated Service Network (VISN) Director. The

information includes outpatient quality composites and individual quality measures for Veterans receiving care in CBOC settings as well as an assessment of performance for contractor-staffed CBOCs. A revision of VHA Handbook 1006.1, Planning and Activating Community Based Outpatient Clinics, is in process. Updating monitoring criteria is an ongoing process.

Training about and monitoring of TBI and MST screening has been expanded and enhanced, including updated on-line modules, materials specific for primary care and mental health providers, and emphasis for CBOC issues. A system of sustained training, consultative support, and recurring reports with associated monitoring is in place and will be ongoing.

VHA has implemented nine inspections per year per facility using a standardized inspection tool to verify availability and use of standardized operating procedures (SOP) as well as employee competencies. The inspection results are reviewed, tracked, and trended nationally. Facilities that are not in compliance are required to develop action plans to address concerns. In reviewing and trending these data, VHA focuses on nearly 200 specific points of review. VHA has collected more than 100 inspections with the new template and is persistently following up on deficient sites. To reduce variation and increase standardization of processes to the maximum extent possible, VHA has increased consultative visits from expert staff, enhanced training, and instituted a national database to maintain manufacturers' instructions for use.

The CT protocol optimization guide is now in use. It includes important parameters for monitoring patient dose, provides reference and alert values, and describes how facilities may identify protocols that result in unusually high patient dose.

Patient education materials that include information about the effects of cumulative radiation exposure are now available, and the field has been directed to provide this information to patients undergoing a CT scan.

Planned 2012 Milestones with estimated completion quarter

VBA will enhance the rating application used to prepare disability decisions so that historical data on denied claims are not overwritten by subsequent decisions. **(Q1)**

VBA will implement any process improvements identified during the review of claims denied for PTSD due to MST. **(Q1)**

VHA Handbook 1006.1 will be completed to better define Network responsibility and require more consistency in quality of care and business processes involving CBOCs. **(Q4)**

Updates of requirements for training and verification of competencies for staff reprocessing RME are in process. **(Q1)**

Guidance regarding the use of fluoroscopy will be published. **(Q4)**

OIG Sub-Challenge #1B: Access to Care

VHA faces significant challenges related to access to care in several areas.

These areas include ensuring Veterans receive compensation and pension (C&P) medical examinations, nursing home care at State Veterans Homes (SVH), and guide and service dogs. Providing medical care to homeless Veterans, Veterans residing in rural areas, and Veterans who are residents of the U.S. Virgin Islands is also challenging VHA.

VBA relies on VHA medical facilities to perform C&P medical examinations to determine the degree of disability or provide a medical opinion as to whether a disability is related to the Veteran's military service. A 2010 OIG audit found that VA medical facilities do not consistently commit sufficient resources to ensure Veterans receive timely C&P medical examinations. This occurred because VHA has not established procedures to identify and monitor resources needed to conduct C&P medical examinations and to ensure resources are appropriately planned for, allocated, and strategically placed to meet examination demand. VHA's ability to complete C&P examinations in a timely and efficient manner is of extreme importance due to VBA's claims processing backlog. Further, because VHA committed insufficient resources to the C&P medical examination program, many Veterans did not receive timely C&P medical examinations. VHA is taking steps to capture workload data and analyze staffing models and is also developing standards on the amount of time that should be allotted when scheduling appointments for each examination.

OIG continues to monitor VA's ability to complete C&P examinations in a timely and efficient manner. During FY 2011, VHA continued to face C&P examination backlogs. In at least one Veterans Integrated Service Network (VISN), some VHA facilities conducted C&P examination "blitzes" during the spring of 2011. These facilities dedicated up to 80 percent of their primary care appointment schedules over the course of 3 weeks to address a backlog of C&P examinations. While VHA recently reorganized responsibility for VHA's C&P examination efforts under a new Office of Disability and Medical Assessment, report recommendations made in our 2010 audit report remain open. VHA needs to implement procedures to better capture data on C&P examination workload, costs, and productivity and use this data to ensure appropriate resources are dedicated to completing C&P examinations.

VHA also faces a significant challenge in ensuring Veterans obtain needed nursing home care. In March 2011, an OIG audit of VHA's State Home Per Diem Program reported that two states were denying care to eligible Veterans and none of the eight VAMCs the OIG visited had strengthened their outreach efforts to ensure Veterans denied access to SVH nursing home care obtained access to care from other VA sources. This occurred because VAMCs did not provide SVHs information on VA nursing home care options for distribution to Veterans. VHA can address this challenge by providing fact sheets on VA nursing home care options to SVHs for distribution to eligible Veterans, determining the SVHs that have denied eligible Veterans access to care, and developing and initiating a plan to conduct specific and targeted outreach activities.

The March 2011 audit also reported that VA medical facilities need to improve their oversight of SVHs to reduce risks of Veterans receiving inappropriate nursing home care. In addition, VAMCs did not properly document or ensure timely SVH submission of 32 percent of eligibility determinations and 55

percent of medical care approval requests for the sample of Veterans reviewed by OIG. This occurred because of ineffective VHA policies and procedures, insufficient oversight, and inadequate staff training. As a result, increased risks exist that Veterans will not receive needed nursing home care, and SVHs will not provide appropriate medical care. By revising VHA policies and procedures, ensuring VISNs establish oversight procedures, and providing training to VAMC staff responsible for SVH oversight, VHA can reduce the risks of Veterans receiving inappropriate SVH nursing home care.

Another challenge facing VHA relates to the Guide and Service Dog Program's implementation criteria and process of determining the appropriateness of using service dogs to assist Veterans with mental and physical impairments. For several decades, VHA assisted visually impaired Veterans in obtaining guide dogs. Only since 2008 has VHA started assisting mobility and hearing impaired Veterans with service dogs—6 years after being authorized to do so. Since FY 2009, VHA has provided financial support to just over 230 Veterans for guide dogs and financial support to only 8 Veterans for service dogs. VHA needs to provide sufficient guidance to staff to ensure decisions are consistent on Veterans' requests for service dogs. Furthermore, VHA also needs to provide comprehensive interim guidance to ensure staff is aware of qualifying criteria for service dog benefits and the benefit application process. VHA will need to ensure staff complies consistently with the new guidance once it is issued.

VA has undertaken the mission of ending homelessness among Veterans, but continues to face difficulties in serving this population of Veterans appropriately. In many instances, VHA has provided compassionate care to a most challenging population; however, the successful provision of health care to Veterans without a fixed address and with the disease burden typical of this population will require comprehensive programs and outreach. VHA faces challenges in identifying Veteran subpopulations most susceptible to homelessness, and in placing homeless or at-risk Veterans into programs that are demonstrated to be effective. Furthermore, the diagnosis and treatment of complex cardiac disease, gastrointestinal disorders, cancer, and substance abuse are examples of medical disorders that are a challenge to provide care for in disadvantaged areas and to homeless Veterans. However, VA recognizes that through the implementation of the Surgical Complexity Model, limits must be set on the types of surgical care that can be directly provided by VHA in selected underserved areas. This complex and challenging endeavor will involve 13 discrete VA programs and an investment of more than $20 billion over 5 years.

VHA needs to strengthen the management of rural health care funding to ensure that rural health projects meet VHA's Office of Rural Health's (ORH's) goals of improving access and quality of care for rural Veterans. ORH was created in February 2007 to conduct rural health research and develop policies and programs to improve health care and services for approximately 3.3 million rural Veterans. Men and women from geographically rural areas make up a disproportionate share of service members and comprise about one-third of all Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND) enrolled Veterans.

In April 2011, OIG reported that VHA needed to improve the management of rural health funding, finding that ORH did not adequately manage the use of rural health funds for fee care and their rural health project selection process. Additionally, ORH did not monitor project obligations and performance measures. This occurred because of a lack of financial controls, the absence of policies and procedures to ensure staff followed management directives, and inadequate communication with key stakeholders.

Also, ORH lacked a project monitoring system, procedures to monitor performance measures, and a process to assess rural health needs. As a result, OIG determined that VHA lacked reasonable assurance that ORH's use of $273.3 million of the $533 million in funding received during FYs 2009 and 2010 improved access and quality of care for Veterans residing in rural areas. To address this challenge, VHA must identify high-impact projects during the formulation of the program's annual budget requests and strengthen its future proposal selection process. Completing these actions will improve VHA's accounting of funds and measuring of the rural health program's impact on the health care of rural Veterans and their families.

An OIG review also found that access to health care for Veterans who are residents of the U.S. Virgin Islands needs improvement. Improvement areas include ensuring that English language proficiency is documented for all employees occupying direct patient care positions, scheduling timely initial primary care appointments, and providing the same level of care as other Veterans in the VISN receive. To address this issue, VHA is considering the feasibility of sending medical examiners to the U.S. Virgin Islands to perform C&P examinations that do not require medical specialists or non-portable specialized medical equipment.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Under Secretary for Health

Completed 2011 Milestones

VHA has committed additional resources to improve the C&P medical examination program. For example, the VHA Office of Disability and Medical Assessment was established to develop and implement strategies to address the evolving needs of the VHA C&P medical examination programs as well as ensure appropriate measuring, monitoring, and improving quality and timeliness. Timeliness has improved. Currently, VHA C&P timeliness for exams is 29 days (standard is 30 days), and IDES timeliness for exams is 40 days (standard is 45 days).

VHA developed the "VA Long-Term Care Resources Summary Fact Sheet" about nursing home care options and implemented a communication plan to ensure effective distribution of this fact sheet, which has been shared at the National Association of State Veterans Homes and National Association of Directors of State Veterans Homes conferences. Policy updates, an improved quality assurance review process, a new State Home Audit Tool, and additional training are now in place to ensure that care provided by State Veterans Homes is appropriate for Veterans' needs.

VHA has concentrated on developing expertise about what guide and service dogs can do for Veterans and what training is needed to ensure the optimum benefit for Veterans. Draft regulations were published in the Federal Register. Policy and Clinical Practice Recommendations are being developed.

VA has concentrated its efforts to provide services to end homelessness:

- Homeless outreach initiatives reached more than 150,000 Veterans, a 24 percent increase from the previous year.

- Department of Housing and Urban Development-Veteran Affairs Supported Housing (HUD-VASH) actively housed 24,733 Veterans.
- The new Supportive Services for Veteran Families (SSVF) program awarded $59.5 million to 85 community agencies in 40 states and the District of Columbia.
- VA launched the Homeless Operations Management and Evaluation System, an online data collection and case management system that tracks homeless Veterans as they move.
- VA allocated funding to hire 407 homeless or formerly homeless Veterans as vocational rehabilitation specialists through the Homeless Veterans Supported Employment Program; nearly 90 percent have been hired, trained in Supported Employment (SE) service provision, and are now providing SE services to other homeless Veterans.
- VA provided funding for 15 Community Resource and Referral Centers (CRRC) to co-locate with services from local and community agencies and other Federal agencies to provide direct assistance to homeless Veterans as well as referral to permanent and transitional housing services.

The Office of Rural Health has improved management and provided more effective services to Veterans in rural areas, including:

- Hiring experienced and qualified staff.
- Developing and implementing a 2011 Spend Plan in accordance with the *Standards for Internal Control in the Federal Government* for monitoring of financial transactions.
- Implementing new procedures related to funding execution and project/program management and establishing tight controls for proposal review/approval against specific project funding rating criteria.
- Improving data collection.
- Evaluating projects to ensure goals, objectives, and milestones are relevant, up-to-date, and assigned to each project as well as appropriately monitoring and measuring performance.

The need to ensure English language proficiency for physicians, nurses, and residents is being emphasized at the VA medical facility in the U.S. Virgin Islands.

Planned 2012 Milestones with estimated completion quarter

VA will identify an internist to visit the U.S. Virgin Islands at least monthly to perform non-specialty Compensation and Pension exams. **(Q1)**

The final service dog regulations and related policy about covered benefits for training, veterinary care, and hardware will be completed as well as appropriate communications to the field. **(Q2)**

VA will host a national conference about having animals in health care settings. **(Q1)**

VA will address the needs of homeless Veterans by:

- Decreasing the number of homeless Veterans to 59,000 in collaboration with HUD. **(Q4)**
- Developing a new Transition-in-Place housing model with a goal of obligating approximately $21 million in capital, special needs, and/or transition in place grants to serve approximately 30,000 Veterans. **(Q4)**

- Improving employment outcomes through the Homeless Veterans Supported Employment Program (HVSEP) to provide services to approximately 31,000 homeless Veterans. **(Q4)**
- Establishing a training curriculum and training National Cemetery Administration (NCA) mentors for the NCA Veterans Apprenticeship Program. **(Q4)**
- Providing $100 million for community-based service grants to serve approximately 22,000 Veterans and families through the SSVF program started in 2011. **(Q4)**
- Increasing VA's participation in Veterans Treatment Courts and public outreach/education to Veterans, their families, and justice system staff to address the growing numbers of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans who need these services. **(Q4)**
- Making all CRRCs fully operational. **(Q1)**

The Office of Rural Health will:

- Fully implement its review of project milestone progress quarterly reports and access and quality measurement data. **(Q1-4)**
- Begin monitoring project data to ensure reports and evaluations of data are timely and provide an accurate assessment of the current status of each project. **(Q1)**
- Regularly review financial reports to ensure efficient and effective utilization and obligation of funds. **(Q1-4)**
- Complete the identification of those geographic areas with the most needs to align resources to address the greatest health care needs. **(Q1)**

OIG Sub-Challenge #1C: Effective Treatment of New and Significantly Increased Health Problems Associated with OEF/OIF/OND

VHA faces significant challenges in the treatment of Veterans with health problems associated with OEF/OIF/OND service. As aforementioned in sub-challenge 1A, the current global conflicts have highlighted at least four specific issues that VA must adequately address: PTSD, TBI, substance abuse, and women's health. Returning war Veterans must be screened, diagnosed, and treated appropriately for PTSD. Their treatment must be sufficiently described in their medical records to permit a future analysis, if appropriate, of the outcomes of therapies for this war-related illness. Likewise, TBI diagnosis requires better definition and research to determine the best therapies. VA is challenged to aggressively treat Veterans with the best current therapies and quickly advance the state of current knowledge to improve the understanding of this condition.

VHA's challenge in treating substance abuse involves developing appropriate treatment programs for use nationwide. Physical and psychic pain often results in over-reliance on addictive medications and substances to control pain. Adequate treatment programs in VA for substance abuse are limited in many areas of the country. Treatment is complex, as the mental and physical symptoms of the disease are not easily or quickly relieved. VA must work with the substance abuse treatment community at-large to optimize opportunities for treatment of this complex illness.

Finally, though many medical conditions faced by women warriors are similar to those faced by men, many are different. VA must provide treatment options appropriate for female Veterans' health care needs. This is especially true for MST, in which women Veterans may require specialized outpatient

mental health services focusing on sexual trauma, specialized sexual trauma treatment in residential or inpatient settings, or treatment in a program for women only. Women often have additional responsibilities that put different constraints on their ability to access health care, when compared to men; and these constraints must be creatively and timely addressed.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Under Secretary for Health

Completed 2011 Milestones

VA published a revision to VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program, requiring programming specific to the needs of OEF/OIF/OND Veterans. The handbook also includes guidance regarding substance abuse and PTSD treatment services as well as information specific to the needs of women Veterans.

Vet Centers continue to provide PTSD counseling services to combat Veterans. The Readjustment Counseling Service (RCS) worked specifically with Vet Centers to correct problems regarding clinical supervision and consultation. RCS also has begun to use an electronic template to facilitate monitoring of issues identified in quality reviews.

VA began training staff at large intensive outpatient programs on the use of contingency management treatment, an evidence-based approach to the treatment of substance use disorders.

VA provided training about the use of the Brief Addiction Monitor to facilitate assessment of treatment progress to substance use disorder specialty treatment staff nationwide.

VA has developed strong collaborative ties with the Department of Defense (DoD) to complete a literature review and gap analysis of women Veterans' mental health needs and services in VA and DoD.

To address the needs of the growing number of women Veterans, VA has:
- Trained more than 1,000 VA providers in women's health primary care.
- Launched a call center to contact every woman Veteran about VA health care and services available to women Veterans. During the first month in June 2011, the Women Veterans Call Center reached nearly 1,000 women Veterans or their representatives.
- Hosted the 5th National Summit on Women Veterans involving more than 700 participants where the Secretary of Veterans Affairs announced the creation of a VA Task Force on Women Veterans charged to develop a comprehensive VA action plan that will focus on key issues facing women Veterans and the specific actions needed to resolve them.
- Planned three drop-in childcare service pilots for women Veterans with VA appointments.

Service connection or receipt of disability compensation is not required to receive free treatment for conditions resulting from MST. To address needs of women Veterans who have experienced MST, every VA facility has:

- A designated MST Coordinator who can facilitate access to appropriate VA services and programs, state and Federal benefits, and community resources.
- Providers knowledgeable about treatment for the aftereffects of MST.
- Vet Centers that provide either direct counseling or assessment and referral for MST issues. Currently, over 150 Vet Centers across the Nation have a Staff Training Experience Profile (STEP) qualified MST Counselor. All these counselors provide individual counseling and group counseling where appropriate for this cohort of Veterans.

For Veterans who need more intense treatment and support, VA offers specialized sexual trauma treatment in residential or inpatient settings.

Planned 2012 Milestones with estimated completion quarter

To ensure additional accountability for high quality clinical supervision and consultation in Vet Centers, VA will add a performance goal to the Team Leader Performance Plans for 2012 that specifies the required standards for clinical supervision and consultation in Vet Centers, including documentation of inpatient records. **(Q1)**

VA will implement contingency management treatment in large intensive outpatient substance use treatment programs. Specialty substance use disorder treatment programs will implement use of the Brief Addiction Monitor. **(Q4)**

Each medical center outpatient clinic and CBOC will have a minimum of one trained (in VHA's women's health mini-residency program or equivalent training) or experienced Designated Women's Health Provider. **(Q4)**

Ninety percent of all currently identified bathroom and other women Veteran privacy deficiencies will be corrected. **(Q4)**

VA will launch two childcare sites in fall 2011 and a third in the summer of 2012. **(Q3)**

OIG Sub-Challenge #1D: Accountability of Pharmaceuticals in VHA Medical Facilities and Consolidated Mail Outpatient Pharmacies (CMOPs)

VHA medical facilities and Consolidated Mail Outpatient Pharmacies (CMOP) dispensed approximately 130 million prescriptions for VA patients and spent about $3.8 billion on pharmaceuticals in FY 2009. While VA has made significant strides to safeguard inventories of controlled substances regulated under the *Controlled Substance Act of 1970*, increased attention must be paid to non-controlled drugs. Of the $3.8 billion in VA's pharmaceutical spending, approximately 95 percent was for non-controlled drugs.

In FY 2009, OIG issued a health care inspection of selected pharmacy operations in VHA facilities. OIG determined that 33 of 43 facilities experienced drug diversions during 2008. VHA faces a significant challenge in ensuring that its inventories of non-controlled drugs are safe from undetected theft or diversion. Furthermore, two OIG reports issued in 2009 identified significant deficiencies in accountability over non-controlled drugs at VHA medical facilities and CMOPs. OIG found medical

facilities and CMOPs could not accurately account for non-controlled drug inventories because of inadequate inventory management practices and inaccurate pharmacy data.

VHA also needs to strengthen its inventory management practices, ensure all pharmacy transactions are appropriately recorded, and improve its pharmacy information management systems. Both VHA's Veterans Health Information System and Technology Architecture (VistA) and CMOP's inventory management software require improvements in order to allow facilities and CMOPs to better account for pharmacy inventory.

VHA launched the Pharmacy Reengineering project in 2003 to make improvements to VistA. Although the project was slated for completion in 2005, it has been significantly delayed; it is now estimated that the project may not be completed until 2018. As needed upgrades may take years to be fully implemented, it is vital that VHA take more immediate action to improve accountability over non-controlled drugs.

VA's Program Response
Estimated Resolution Timeframe: 2014
Responsible Agency Official: Under Secretary for Health

Completed 2011 Milestones

Inventory management systems at all seven CMOPs were reviewed to identify gaps between current and state-of-the-art practices.

To ensure appropriate internal controls are in place and that pharmacy managers and staff accurately and consistently record drug-dispensing activity, VA has done the following:

- Completed implementation of VHA Directive 2010-039, Compliance with the Management of Non-controlled Drugs.
- Conducted and completed a wall-to-wall inventory report.
- Established this inventory as an annual requirement.
- Reviewed the inventory and selected non-controlled substances reports by comparing VA's results with nationally accepted variances to identify concerns.
- Addressed identified concerns at specific sites.
- Began using a Web-based national reporting tool and monitored drug dispensing activity for selected non-controlled drugs that are high cost or at high risk for diversion each year.
- Reviewed over 800 quarterly variance reports on drug names.
- Continued to provide training on the currently available inventory management tools.

Planned 2012 Milestones with estimated completion quarter

Issue a contract solicitation to either rewrite the existing CMOP inventory management software or purchase existing third-party software. **(Q1)**
Conduct and analyze the results of the annual wall-to-wall inventory. Address concerns at specific sites. **(Q2)**

Deliver software to CMOPs for testing. **(Q4)**

OIG Sub-Challenge #1E: Health Care Business Processes

VHA is a large and complex organization that must improve its business processes to provide cost effective services to Veterans. As previously discussed in Challenge 1A, VHA has demonstrated difficulty in providing proper oversight of the CBOC contracting process. Improper fiscal management diminishes the ability of VHA to provide for the needs of all Veterans.

VHA has increased its attention to nurse staffing standard implementation, as the determination of the number and type of nurse staff required is critical to ensure that clinical and financial performance objectives are achieved. However, VHA has not devoted sufficient attention to physician staffing standards, which are important to ensure the proper combination of physicians at each facility.

VHA needs to improve its processes involving the delivery of payment to non-VA providers at fair and reasonable prices. Under the Non-VA Fee Care Program, VA facilities may authorize Veterans to receive treatment from non-VA health care providers when certain services are unavailable at VA facilities, when services cannot be economically provided due to geographic inaccessibility, or in emergencies when delays may be hazardous to life or health. In 2009, OIG reported that VA improperly paid 37 percent of outpatient fee claims, resulting in $225 million of outpatient fee overpayments and $52 million of outpatient fee underpayments during FY 2008. OIG estimated $1.1 billion in overpayments and $260 million in underpayments over a 5-year period.

In 2010, OIG completed two additional reviews of the Non-VA Fee Care Program. One review determined VA had not established controls designed to prevent and detect outpatient fee care fraud. The other review indentified VHA problems in managing the administration of inpatient fee care. The second review also concluded that Non-VA Fee Care Program claim processing inefficiencies occurred because of its decentralized structure and use of a labor-intensive payment processing system. As a result, VA did not have reasonable assurance that VA facilities were appropriately utilizing resources to serve the health care needs of Veterans and accurately reporting financial information that affects future planning and allocation of health care resources. In FY 2011, VA implemented our recommendations on policies and procedures, training, oversight, and claim processing system improvements from our outpatient, inpatient, and fraud program reviews. However, VA still faces ongoing financial and claim processing challenges in their Non-VA Fee Care Program.

Another health care business challenge VHA faces is to improve its process to identify billable fee claims and system of controls to maximize the generation of Medical Care Collection Fund (MCCF) Program revenue from non-VA care, often referred to as “fee care.” The purpose of the MCCF Program is to recover costs of medical care that VA provides to Veterans who have private health insurance, referred to as third-party insurance. VA is authorized to collect and deposit third-party health insurance payments in its MCCF, which VA uses to supplement its medical care appropriations. Under the MCCF Program, VA bills third-party health insurers for nonservice-connected medical services provided by VA or fee care. VA bases its insurance billing rates on reasonable charges, which are the amounts that insurers would pay private sector health care providers in the same geographic area for the same services. In FY 2010, the MCCF Program collected approximately $1.9 billion in total third-party revenue

and an additional $900 million in first-party and other revenue sources. The third-party revenue constituted 69 percent of the total $2.8 billion revenue collected by the MCCF Program in FY 2010.

In May 2011, OIG reported that VHA missed opportunities to increase MCCF revenue by not billing third-party insurers for 46 percent of billable fee care claims. VHA missed billing opportunities because they did not have an effective process to identify billable fee claims and a system of controls to maximize the generation of MCCF fee care revenue. As a result, OIG estimated that VHA could increase third-party revenue by $110.4 million annually or by as much as $552 million over the next 5 years.

VHA has increasingly relied on the Fee Care Program to provide care to Veterans who cannot easily receive care at a VA medical facility. By implementing an effective process for identifying billable fee claims and augmenting that process with a system of controls, VHA can improve its capability to provide care to our Nation's Veterans and maximize revenue collections.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Under Secretary for Health

Completed 2011 Milestones

To address the challenge of providing proper oversight of the CBOC contracting process, VA uses statistical reports, including assessment of performance for contractor-staffed CBOCs, to inform the quarterly evaluations involving Veterans Integrated Service Network (VISN) Directors and parent facility directors about how to improve CBOC performance. Updating of monitoring criteria is an ongoing process.

VHA is identifying parameters for determining the number of full time equivalents (FTE) and hours in the context of contracting for scarce medical resources. This work will inform the development of staffing standards in VHA facilities. VHA is also exploring the use of relative value units (RVU) to ensure the proper combination of physicians at each facility. RVUs are used in other health care systems, and VHA is investigating how these can be applied to provide primary and complex specialty care in the unique situations throughout VHA.

To improve performance related to payment for fee care services, VA:

- Published a final rule to standardize VA payments for inpatient and outpatient health care professional services and other medical services associated with non-VA outpatient care.
- Evaluated the current non-VA fee care program including an audit of the accuracy of payments made during 2011.
- Published procedure guides and implemented related training.

To address fraud management, VA has implemented a program integrity/fraud management plan including training at all levels within the organization, developed a pilot using predictive modeling to assess potential fraud/waste or abuse cases, and finalized a contract to support a long-term technology solution intended to move to a pre-payment environment.

VA's Office of Business Oversight (OBO) continued oversight of VHA field compliance with Non-VA Care Program policies and procedures. In instances of non-compliance, OBO identified the root causes and made recommendations to VHA senior officials to correct deficiencies. OBO will monitor all recommendations issued in 2011 until they are completed.

Planned 2012 Milestones with estimated completion quarter

VHA Handbook 1006.1, Planning and Activating Community Based Outpatient Clinics, Part 5, Monitoring and Evaluation Process, will be revised to better define VISN responsibility and require more attention to business processes. **(Q4)**

The Under Secretary for Health will receive recommendations about physician staffing standard parameters to be used in contracting for scarce medical services together with action plans with timelines and milestones for implementation. **(Q3)**

The results of the 2011 evaluation of the non-VA fee care program will be reviewed; process changes will be identified and implemented to enhance revenue collections. **(Q3)**

VHA will establish a framework to identify a target for collection of MCCF dollars to maximize revenue. **(Q3)**

VA will continue oversight of VHA field compliance with Non-VA Care program policies and procedures through regular reviews conducted by OBO as part of its 2012 Annual Review Plan. Identifying and reporting on non-compliance will assist VHA senior officials in addressing the issues identified during field reviews, including systemic issues. **(Q4)**

OIG CHALLENGE #2: BENEFITS PROCESSING

-Strategic Overview-

Persistent, large inventories of pending claims for compensation benefits have been a recurring challenge for VBA. VBA faces an increasing disability claims workload from returning OEF/OIF/OND Veterans, reopened claims from Veterans with chronic progressive conditions, and additional claims from an aging Veteran population. The claims workload is expected to further increase based upon new eligibility guidelines related to PTSD and Agent Orange presumptive conditions. The complexities of benefits laws and their interpretation, court decisions, technology issues, workload, and staffing issues contribute to VBA's benefit processing challenges.

Long-term efforts to improve the quality of benefits claims decisions also continue to present a significant VBA challenge. During the 5-year period from FYs 2006 through 2010, VBA's national accuracy rates for rating claims decisions remained the same or declined every year going from 88.6 percent in FY 2006 to 83.8 percent in FY 2010. VBA's recent decline in rating accuracy has moved them further from the VBA strategic target of 90 percent accuracy. Increases in VA funding levels have enabled VA to hire additional claims examiners to help reduce the backlog of pending claims, but VA now faces a continuing challenge to train and incorporate the examiners effectively into a productive workforce. With the significant expansion of its claims workforce through current recruitment efforts

and increasing receipt of claims from Veterans, VA will face additional significant challenges in the accuracy and consistency of benefit decisions. VA also faces major challenges managing the Post 9/11 GI Bill Program as VA implements new legislation providing enhanced educational benefits to Veterans.

OIG Sub-Challenge #2A: Effectively Managing Disability Benefits Claims Workload

VBA continues to experience challenges associated with disability benefits claims that are rising faster than VBA's ability to address this growing workload. In FY 2010, VBA completed 1.95 million rating and non-rating claims, resulting in an end-of-year claims inventory of almost 726,000 claims, up 13 percent from FY 2009's ending inventory of 580,000. As of June 30, 2011, VBA's rating and non-rating inventory had climbed to an unprecedented level of about 1.1 million claims. The June 2011 inventory represents dramatic increases of 51 percent increase from 6 months earlier and 81 percent from the end of FY 2009. A portion of this increase is the result of claims related to conditions such as Parkinson's disease, ischemic heart disease, and hairy cell leukemia and other chronic b-cell leukemias, which VA designated as presumptive disabilities for Veterans exposed to Agent Orange. Many of these claims are subject to strict rules for determining the date of claims as laid out in a U.S. District Court decision in *Nehmer v. U.S. Department of Veterans Affairs* (Nehmer claims). However, even without the *Nehmer* claim inventory, VBA's claims inventory increased significantly. As of June 30, 2011, the non-*Nehmer* rating and non-rating claim inventory of about 1 million claims represented a 37 percent increase from 6 months earlier and 72 percent from the end of FY 2009.

VBA also continues to struggle with achieving its strategic goal of averaging 125 days to complete rating claims. From 2009 to 2010, the average number of days for VBA to process rating claims increased from 161 to 166. For the FY to date through May 2011, VBA continued to move further from its strategic goal by averaging about 170 days to process rating claims.

OIG has completed several audits and reviews to assist VBA in addressing this challenge. In 2009, OIG completed an audit of claims rating decisions that exceeded 365 processing days at VA regional offices (VARO). The audit found that 90 percent of the 11,000 claims pending for more than 365 days were unnecessarily delayed an average of 187 days because of inadequate workload management by VBA. VAROs needed to improve workload management by linking workload management plans to VBA timelines, targets, and goals and execute these improved plans to avoid the deficiencies that cause claims processing delays.

In 2010, OIG conducted an audit to evaluate the effectiveness of VBA's Compensation Program claims brokering. VBA's main goals of brokering are to reduce claims backlogs by expediting processing and helping VAROs meet their processing timeliness targets. VBA has increasingly used claims brokering to try to better align VAROs' workload with staffing resources and address the challenge of reducing claims backlogs. From FY 2006 through FY 2009, the number of brokered claims grew from 90,000 to 171,000, and the percent of claims brokered increased from 12 to 18 percent.

The audit found that VBA can improve the effectiveness of claims brokering by ensuring area offices consider additional factors affecting timeliness and accuracy and strengthen controls over VARO informal claims brokering. For nearly 171,000 brokered claims completed during FY 2009, OIG projected that the average processing time of 201 days would have been 49 days less had VBA avoided the claims

processing delays identified during the audit. OIG also projected that area offices brokered about 54,000 (46.2 percent) of the nearly 117,000 claims brokered for rating actions to facilities with lower rating accuracy rates than original Veteran Service Centers (VSCs). During the audit, OIG also noted that three VAROs brokered claims without area office approval. To address these issues, VBA needs to revise brokering policies and procedures and include timeliness and accuracy measurements in performance plans for directors of VAROs that process brokered claims. In June 2010, VBA interrupted most claims brokering to address the additional challenge of processing *Nehmer* claims. VBA officials have stated they plan to resume full scale brokering in October 2011.

Efforts are also needed to improve tracking and provide accountability of Veterans' claims folders, which contain personally identifiable information. VBA relies upon the Control of Veterans Records System (COVERS) to track Veterans' claims folders. A 2009 audit projected that approximately 296,000 claims folders of the 4.2 million claims folders assigned to VAROs nationwide were in locations that were different from that shown in COVERS. The audit also projected that approximately 141,000 claims folders were lost. Lost claims folders further impair the Department's ability to provide accurate and timely benefits. To gain full control and accountability over Veterans' claims folders, VBA needs to implement all the report recommendations.

OIG inspections disclosed similar findings with regard to mail processing and claims folder management. At 63 percent of 16 VAROs inspected, Triage Team staff improperly managed claims-related mail. Triage Teams are responsible for reviewing, controlling, and processing or routing all incoming mail received from the VARO mailroom. Untimely control and processing of mail can cause delays in processing disability claims. Triage Team members did not timely record receipt and process 21 percent of the incoming mail. In addition, staff did not properly use COVERS to track the location of 24 percent of claims-related mail. At one VARO, OIG found 1,462 pieces of mail waiting to be associated with Veterans' claims folders.

In recent years, VBA has significantly increased its claims processing workforce in an effort to reduce claim-processing times. In 2007 and 2008, VBA hired about 2,800 claims examiners. In 2009, VBA filled an additional 2,300 temporary claims examiners positions funded by the *American Recovery and Reinvestment Act of 2009*. As VBA is able to hire additional permanent employees, it will need to provide these employees the necessary claim-processing training to become effective members of the workforce.

In 2009, an OIG audit concluded that VBA needs to collect better information on its current workforce, such as the number of overtime hours worked, to utilize its workforce effectively. VBA officials also reported challenges maintaining productivity while also ensuring reviews of the work completed by new employees. Since the OIG audit, VBA began to collect and utilize more complete information on its workforce capacity, which should reduce VBA's risk of underestimating its workforce needs to address its growing claims inventory.

In FY 2010, OIG reported that VBA call centers and Internet-based Inquiry Routing and Information System (IRIS) did not provide timely and adequate information. In FY 2008, VBA began consolidating public contact activities into eight national call centers, one pension call center, and one IRIS center. In FY 2009, individuals reached an agent 76 percent of the time. Of those reaching an agent, agents

answered 72 percent of their questions correctly. When OIG combined VBA's reported data on access and accuracy, OIG concluded that any one call placed by a unique caller had a 49 percent chance of reaching an agent and getting the correct information. This occurred because VBA did not have a central entity to provide leadership and guidance, establish sufficient performance standards to evaluate timeliness and accuracy, provide adequate training, and implement an efficient call-routing system. VBA initiated some corrective measures by recruiting for a contact operations manager, adjusting the routing of calls, and increasing the number of telephone lines. In FY 2011, VBA plans to implement a new process to route calls more efficiently.

Opportunities also exist for VAROs to improve appeals management processing timeliness. VARO staff completed over 1 million ratings in FY 2010, an increase of 19 percent since FY 2008. With the increased number of ratings, the number of appeals increased by over 30,000—about 13 percent each year since FY 2008. VBA has not been able to keep up with the increased number of appeals, and as a result, the backlog of appeals has risen by 30 percent from 160,000 appeals in FY 2008 to 209,000 in FY 2010. VBA officials have also reported the number of open appeal cases is likely to increase because, in FY 2011, they devoted a significant number of ratings personnel to process Nehmer claims.

As part of their efforts to reduce the claims backlog, VBA and VHA collaborated in the development of Disability Benefits Questionnaires (DBQ) to replace the C&P examination reports currently in use. DBQs are streamlined medical examination forms designed to capture essential medical information for purposes of evaluating VA disability claims. DBQs can be completed not only by VHA and VA-contracted clinicians, but also by Veterans' private physicians. OIG will be assessing and monitoring controls the Department implements over the use of DBQs.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Under Secretary for Benefits

Completed 2011 Milestones

The *Nehmer*-related workload is extremely complex, and claims are completed at a rate of production less than half the normal expectation. In 2011, non-*Nehmer* claims brokering to Resource Centers was suspended to focus on completing *Nehmer* cases. Pre-*Nehmer* brokering activities were modified significantly to combat the *Nehmer* workload and 14 Day-one Brokering Centers (D1BC) were developed to receive and process all *Nehmer* claims. As of September 30, 2011, 133,467 *Nehmer* cases have been completed.

In 2010, VBA revised guidance clearly defining the link between workload management plans to claims processing timeliness targets and goals. The guidance also requires workload management plans be designed and implemented in a way that prevents inefficient claims processing practices.

VBA continues to improve tracking and accountability of Veterans' claims folders containing personally identifiable information. Each VBA regional office is required to conduct an annual analysis of COVERS compliance. The COVERS User Guide was updated and guidance issued regarding updating COVERS when transferring or receiving claims and requiring reconfirmation of folder locations every 7 days.

Requirements were developed for a new COVERS report to identify and track rebuilt claims folders and assist in enforcing the 60-day search requirement. VBA is working to improve timeliness and accuracy of mail processing in mail intake units. As of September 30, 2011, the average control time for claim receipts was 10.7 days, a significant decrease from the September 30, 2010, time of 16.4 days.

Quality and average wait time standards at the National Call Centers (NCC) were incorporated into the regional office directors' performance standards. VBA implemented Genesys national call routing nationwide. Calls are now routed to the first available agent nationwide, and the system can record all calls received for quality assurance training. Enhancements were made to call center agent training requirements and compliance.

The Veterans Benefits Management System (VBMS) is VBA's business transformation initiative supported by technology that is designed to dramatically improve benefits delivery. VBMS is designed to assist VA in eliminating the claims backlog. The centerpiece of VBMS is a paperless system, which will be complemented by improved business processes and workflows. Combining a paperless claims processing system with improved business processes is the key to eliminating the backlog and providing Veterans with timely and high quality decisions. During 2011, VBMS was deployed to the Salt Lake and Providence ROs, with a focus on enhancing VBMS Establishment, Workflow, Rating, and e-Folder applications. VBA also began the development stages of VBMS Development, Award and Correspondence applications.

A major project initiated by VBA in January 2011 was the Integration Lab (I-Lab) to evaluate the impact of multiple initiatives on claims processing productivity, timeliness, and quality. The I-Lab supports the development of a standard and consistent operating model to align with the process and technology transformational changes. Specifically, I-Lab distributes work to three separate teams based on the number of issues claimed by the Veteran. Each team is integrated and utilizes a comprehensive screener to move work to the next step in the process. VBA is tracking I-Lab productivity on a weekly basis. Following future analyses, the results will be used in the development of a comprehensive operating model for all regional offices.

The VBA Design Team was created to assist with VBA's transformation by focusing on specific processes such as simplification of the rating and notification letter thus making decisions easier to understand, increasing standardization of the rating process by using logic-based tools, and streamlining the examination process.

Quality Review Teams (QRT) began at 12 pilot sites (3 per Area) on August 1, 2011. These teams are solely dedicated to monitoring station quality, identifying trends/training needs, collaborating with local training components, reviewing Systematic Technical Accuracy Review (STAR) errors, addressing national training issues, addressing local training and other issues for that station, and other appropriate functions. The QRTs have been trained by the National STAR Team and are using the National STAR team review approach.

VA made innovative improvements in claims development, deploying 81 Disability Benefits Questionnaires (DBQ) for use by VA medical facilities with 3 available to private physicians. The DBQs streamline the disability evaluation process by requiring a consistent format for medical evidence. In

November 2010, VBA implemented the Private Medical Records pilot to reduce timeliness for receipt of private medical records. VBA is receiving responses to private medical record requests 23 days faster than non-pilot requests. VBA initiated the Fully Developed Claim program nationwide.

Planned 2012 Milestones with estimated completion quarter

In the second quarter of 2012, D1BCs are expected to complete the *Nehmer* work and resume working brokered cases. D1BCs have RO personnel reassigned to work cases from start to finish. The D1BCs will also be responsible for the timeliness and quality standards on all cases received. **(Q2)**

VBA will deploy the new COVERS report in the VETSNET Release 13. **(Q3)**

Development of national performance standards for NCC agents will be completed and presented to the Union. **(Q1)** NCCs will implement a virtual call-back feature that will allow callers the call-back option for assistance. VBA continues to encourage callers to utilize the eBenefits Web site for Veterans to access claim status, records, and VA forms 24 hours a day. **(Q2)**

VBMS will be deployed to an additional RO to validate production business processes. **(Q1)** Combining a paperless system with improved business processes is key to eliminating the claims backlog and providing Veterans with timely and accurate decisions. The VBMS software will continue to undergo fine-tuning, and the supporting architecture will be scaled to support production and the beginning of national deployment of VBMS. **(Q4)**

VBA will assess the Quality Review Team pilot program and the results will determine further deployment beyond the original 12 pilot sites. **(Q4)**

OIG Sub-Challenge #2B: Improving the Quality of Claims Decisions

VBA continues to experience challenges related to VARO claims processing accuracy, obtaining accurate medical examinations for evaluating residual disabilities associated with a TBI, and processing claims-related mail. During the period October 2010–June 2011, OIG inspected 14 VAROs and identified areas where VARO personnel are challenged to make quality claims decisions.

Staff at the 14 VAROs incorrectly processed 28 percent of 1,554 disability compensation claims, resulting in nearly $4.3 million in overpayments. These processing errors related to claims for PTSD, TBI, disabilities related to herbicide exposure (Agent Orange), and temporary 100 percent evaluations for service-connected conditions requiring surgical or specific medical treatment. Staff at the 14 VAROs was unable to process 39 percent of 294 TBI claims correctly because VHA medical examination reports did not contain sufficient information for VARO staff to make an accurate determination. Further, inaccuracies resulted from staff not properly evaluating the severity of TBI-related disabilities. Generally, VARO staff over-evaluated the severity of TBI-related disabilities because they did not properly interpret the medical examination reports.

Additional VBA efforts are needed to ensure the quality of total disability evaluations. In January 2011, OIG reported that VARO staff continues to inconsistently process temporary 100 percent disability

evaluations correctly. OIG projected that VARO staff did not correctly process evaluations for approximately 27,500 Veterans and that, since January 1993, VBA has paid Veterans a net $943 million without adequate medical evidence. In particular, VARO staff was unable to correctly process 63 percent of 420 temporary 100 percent evaluations because VARO staff did not enter the required future medical reexamination dates into Veterans' electronic records or monitor the electronic notifications for medical examination requests. Entering the future medical exam date generates an automatic notification that alerts VARO staff to request a medical examination to evaluate whether the Veteran's temporary 100 percent disability evaluation should continue. Without this notification, improper payments could potentially continue for the Veteran's lifetime. If VBA does not take timely corrective action, it could overpay Veterans a projected $1.1 billion over the next 5 years. VBA generally classifies these overpayments as administrative errors and does not establish a receivable or expect the Veteran to repay the overpayment.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Under Secretary for Benefits

Completed 2011 Milestones

VHA C&P examiners who conduct TBI examinations completed new training in the VA Talent Management System on performing quality TBI medical examinations. VBA instituted a second-level review requirement for all TBI disability rating decisions.

Regarding the quality of total disability evaluations, OIG attributed the cause of errors identified to VA Regional Office staff not correctly processing evaluations. However, VBA identified multiple computer system errors, rather than employee errors, that accounted for a high percentage of the tracking or monitoring errors noted by OIG. VBA implemented a system modification to ensure that future exam diaries are established for rating issues, even when award action is not necessary. VBA identified records for review that contain temporary 100 percent evaluations for the top three disability-specific problem areas identified (Diagnostic Codes 7715 – Non-Hodgkin's Lymphoma, 7528 – Malignant Neoplasms of the Genitourinary System, and 9411 – Post-traumatic Stress Disorder). In addition, VBA updated training materials related to processing future examination diary notifications and evaluating permanent and total disabilities. VBA validated the folder relocation procedures to ensure that claims folders are not relocated to the Records Management Center when the disability is temporary in nature.

In September 2011, the Institute for Defense Analyses completed the independent 3-year review of VBA's quality assurance program mandated under the provisions of Public Law (P.L.) 110-389, Veterans' Benefits Improvement Act of 2008, and VA provided a final report to Congress.

VBA implemented a Quality Review Team pilot program that created dedicated quality review positions at 12 VBA regional offices. The Nashville Quality Assurance Office conducted training for local quality reviewers that focused on identifying error trends and other weaknesses earlier than those identified through national quality reviews.

VBA implemented innovative tools for the claims decision process. The "Hearing Loss Calculator" tool released in November 2010 and the "Special Monthly Compensation Calculator" tool released in July 2011 utilize rules-based technology to improve timeliness, accuracy, and consistency of rating decisions.

VBA enhanced its Challenge training program to incorporate trainee evaluation and feedback into the course accreditation process, ensuring VBA obtains vital feedback. Enhancements also allow ROs to track the annual training hour requirements for individual claims processors. In addition, VBA deployed 10 training lessons that conform to education industry standards.

Planned 2012 Milestones with estimated completion quarter

VBA will review records containing temporary 100 percent evaluations for the top three disability-specific problem areas identified to assess current disability status and ensure a future examination date is in the Veteran's record. **(Q4)**

VA will assess the final report received from the independent review of our quality assurance program that was conducted by the Institute for Defense Analyses under the provisions of P.L. 110-389, Veterans' Benefits Improvement Act of 2008, and will take appropriate action to further enhance VBA's quality assurance program. **(Q4)**

VBA will assess the Quality Review Team pilot program, and the results will determine further deployment beyond the original 12 pilot sites. **(Q4)**

VBA will continue the development of additional calculators to assist in improving timeliness, accuracy, and consistency of rating decisions**. (Q4)**

VBA will place additional online training material for claims processors into an educational design template recognized as a standard format by the educational design industry. **(Q4)**

OIG Sub-Challenge #2C: VA Regional Office Operations

VBA continues to experience challenges with their 57 VAROs complying with VA regulations and policies and ensuring consistent performance of their VSC operations. OIG's Benefits Inspection Division has reported problems in ensuring VARO personnel complete thorough and timely Systematic Analysis of Operations (SAO) and accurately process claims-related mail. Half of the VAROs inspected during 2010 did not follow VBA policy to ensure SAOs were timely and complete. SAOs provide an organized means of reviewing VSC operations annually to identify existing or potential problems in claims processing and propose corrective actions. If VARO management had ensured staff completed thorough SAOs, they would have identified weaknesses associated with their operations and could have developed plans to correct these shortcomings. In addition, many VAROs did not always control and process mail according to VBA policy. Delays in processing claims-related mail might affect the accuracy and overall timeliness of claims processing.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Under Secretary for Benefits

Completed 2011 Milestones

VBA is constantly striving to identify new ways to improve performance at all regional offices (RO). VBA aggressively monitors regional office performance to develop specific action plans to improve identified problem areas. Oversight is provided through site visits conducted by both the C&P Services and the Area Offices. Regional office directors are held accountable for station performance through annual performance evaluations.

All VBA ROs are required to perform annual SAOs to provide a comprehensive overview of specific divisional functions as well as outline areas for improvement. Procedures and a schedule for completing SAOs are available for each VBA business line. Also, each RO director can establish additional SAOs for local operational issues.

SAOs are reviewed during both Central Office and Area Office site visits. SAO compliance is tracked and monitored closely by both parties. Throughout the year, Area Offices may also request copies of RO SAO schedules and specific completed SAOs for further review.

Planned 2012 Milestones with estimated completion quarter

VBA will continue to review RO SAOs completed during both Area Office and Central Office site visits. VBA will further emphasize the importance of SAOs during the weekly Deputy Undersecretary conference call. **(Q1)**

Another initiative in development is the Intelligent Work Queue (IWQ). This is a computerized, rule-based workload management system that will assist employees in analyzing the work each person has pending and suggesting what is the most effective work to complete for a particular day or week. The IWQ is scheduled to begin field testing and implementation in 2012. **(Q2)**

VBA will continue to pursue the strategic goals established 2 years ago to transform VA into a people-centric, results-driven, and forward-looking organization. This transformation responds to the demands of an era of emerging information technologies, changing demographic realities, and renewed commitments to today's Veterans. By 2015, VA's highest priority goals in transformation are to eliminate the disability claims backlog and ensure all Veterans receive a quality decision (98 percent accuracy rate) in no more than 125 days. VBA continues to work toward eliminating the claims backlog while at the same time establishing the momentum of change across all VBA lines of business. Our multi-pronged approach incorporates transformation across business processes, people, and technology to develop an integrated operating model. **(Q4)**

The VBMS is VBA's business transformation initiative supported by technology that is designed to dramatically improve benefits delivery. VBMS is designed to assist VA in eliminating the claims backlog. The centerpiece of VBMS is a paperless system, which will be complemented by improved business

processes and workflows. Combining a paperless claims processing system with improved business processes is the key to eliminating the backlog and providing Veterans with timely and high quality decisions. During 2011, VBMS was deployed to the Salt Lake and Providence ROs with a focus on enhancing VBMS Establishment, Workflow, Rating, and e-Folder applications. VBA also began the development stages of VBMS Development, Award, and Correspondence applications. VBMS will be deployed to an additional regional office to validate production business processes. **(Q1)** The VBMS software will continue to undergo fine-tuning and the supporting architecture will be scaled to support production. National deployment of VBMS is scheduled to begin during calendar year 2012. **(Q4)**

VBA will begin national implementation of our transformation plan by developing a new operating model based on business processes, people, and technology. Best practices learned from the I-Lab at the Indianapolis Regional Office and the VBA Design Team will be integrated into this plan. The I-Lab combines several initiatives and technological advances, achieving higher productivity and quality through integrated cross-functional teams working claims from start to finish, an intake-processing center with skilled personnel, and a new tool to support efficient workload management. The VBA Design Team was created to assist with the transformation by focusing on specific processes such as simplification of the rating and notification letter thus making decisions easier to understand, increasing standardization of the rating process by using logic-based tools, and streamlining the examination process. **(Q2)**

OIG Sub-Challenge #2D: Improving the Management of VBA's Fiduciary Program

VBA is placing beneficiary VA funds at risk of potential misuse because VBA lacks the elements of an effective management infrastructure to support its Fiduciary Program. VA pays billions of dollars in C&P benefits to disabled Veterans and their dependents. VAROs must consider the competency of beneficiaries in every case involving a mental health condition that is totally disabling or when evidence raises a question as to a beneficiary's mental capacity to manage his or her financial affairs, including VA benefits. For those beneficiaries who are deemed incapable to manage their financial affairs because of injury, disease, or the infirmity of age, VA appoints a fiduciary to manage their VA funds. In its FY 2010 Annual Budget Submission, VA reported approximately $696 million in benefits payments to more than 102,000 incompetent beneficiaries with a cumulative estate value of $3.1 billion.

VAROs have been challenged to make timely competency decisions and fiduciary appointments. OIG inspections found staff at seven VAROs unnecessarily delayed making final competency decisions in 34 percent of the cases reviewed. Delays ranged from approximately 17 to 530 days. VARO workload management plans did not make competency determinations a priority or include measures for oversight of this work. As a result, incompetent beneficiaries received their benefits directly without fiduciaries in place to manage their financial resources. While the beneficiaries were entitled to these payments, fiduciary stewardship may have been needed to ensure effective funds management and the welfare of the beneficiaries. The risk of incompetent beneficiaries receiving benefit payments without fiduciaries assigned to manage those funds increases if staff does not complete competency determinations promptly.

OIG has also found that VBA struggles with consistently and effectively monitoring the activities of fiduciaries and, therefore, VA funds have been at risk of misappropriation by fiduciaries. From April 1,

2006, to March 31, 2011, OIG investigated 131 fiduciary cases and made 65 arrests. In June 2011, an administrative assistant working for an attorney, who was a VA appointed fiduciary, pled guilty to Bank Fraud. An OIG investigation revealed that the administrative assistant forged the attorney's signature on more than 325 checks from several VA beneficiary accounts and wrote checks to herself, which she then deposited into her personal bank account. To conceal the embezzlement, which totaled more than $625,000, the defendant transferred funds from one Veteran's account to another whenever an annual accounting was due to be submitted to VA.

In an FY 2010 audit, OIG reported that many of the same program deficiencies noted in a 2006 audit of the Fiduciary Program persist. VAROs are not consistently taking timely or effective actions to ensure VA-derived income of incompetent beneficiaries is protected. These program deficiencies have occurred because VBA lacks elements of an effective management infrastructure to monitor program performance, effectively utilize staff, and oversee fiduciary activities.

Specifically, OIG reported that the case management system used by the Fiduciary Program to support an array of functions necessary for day-to-day operations of the program has functional and data limitations that have severely affected management's ability to use the system as a tool to support program operations effectively. Since the OIG audit, VBA has developed Fiduciary Program staffing and workload model to guide resource allocation decisions and strengthened its management and oversight of fiduciaries.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Under Secretary for Benefits

Completed 2011 Milestones

VA's Office of Business Oversight (OBO) began oversight of VBA field compliance with fiduciary program policies and procedures. In instances of non-compliance, OBO identified the root causes and made recommendations to VBA senior officials to correct deficiencies. OBO will monitor all recommendations issued in 2011 until they are completed.

VA established the Pension and Fiduciary Service in April 2011 to provide greater oversight and management attention to our Fiduciary Program. This focused approach will facilitate many improvements that are currently underway, including the development of a comprehensive caseload and data management system, and the implementation of revised policies and procedures.

VBA took initial steps to develop a new electronic data repository with enhanced workload management tools and integrated functionality. The business requirements document for the new Fiduciary Program System has been prepared and is currently under consideration. The new system will replace the current Fiduciary Beneficiary System and will better protect the beneficiaries in the Fiduciary Program.

VBA began the consolidation of nationwide fiduciary activities into the following six Hub locations: Salt Lake City, Lincoln, Milwaukee, Louisville, Indianapolis, and Columbia.

VBA conducted three significant training initiatives in 2011. A 3-week centralized training session was conducted in May 2011 for Legal Instruments Examiners (LIEs) hired to support the consolidation of fiduciary activities into Hubs. A second session of LIE training was conducted in August 2011. Lastly, a week-long centralized training session was provided to Field Examiners from each of the fiduciary activities and Hubs in July 2011. Training topics included accounting issues, estate protection, and investigative techniques.

VA required that fiduciaries submit detailed copies of financial institution statements to guard against fraudulent transfers.

VA reported information about the misuse of funds by fiduciaries in VBA's 2010 Annual Benefits Report. In October 2010, VBA provided the ROs a staffing model to use as a guide for local fiduciary activity. VA launched a Web site in January 2011 that provides fiduciaries with resources and information about their duties and responsibilities and the forms and references to assist them in their roles as a fiduciary.

VBA established a workload management standard to ensure that final competency decisions are made within 21 days from the expiration of due process.

Planned 2012 Milestones with estimated completion quarter

VA will continue oversight of VBA field compliance with fiduciary program policies and procedures through a focused review conducted by OBO as part of its 2012 Annual Review Plan. Identifying and reporting on non-compliance will assist VBA senior officials in addressing the issues identified during field reviews, including systemic issues. **(Q4)**

VBA will increase Pension and Fiduciary Service staffing to support increased oversight and management attention of the Fiduciary Program. **(Q1)**

VBA will revise the current fiduciary manual, M21-1MR, Part XI, to provide clear and concise guidance on the Fiduciary Program, clarifying procedures pertaining to misuse of funds. **(Q2)**

VA will complete the development and deployment of the new Fiduciary Program System. **(Q4)**

VBA will complete the consolidation of fiduciary activities into six Hub locations in Salt Lake City, Lincoln, Milwaukee, Louisville, Indianapolis, and Columbia. **(Q4)**

VA will conduct additional centralized training sessions for all LIEs and Field Examiners. **(Q4)**

OIG Sub-Challenge #2E: Addressing Benefit Issues Related to MST

An FY 2011 OIG review observed that VBA generally awarded higher proportions of female Veterans disability benefits for mental health conditions other than PTSD, and generally awarded higher proportions of male Veterans disability benefits for PTSD and TBI. VBA also denied females more often for PTSD, and denied male Veterans more often for a mental health condition other than PTSD, although the denial rates for male and female Veterans for all mental health conditions were almost the same.

The OIG review did not find any evidence that claims processors applied VBA's current policies and procedures differently when evaluating male and female Veterans' disability claims.

The OIG review also identified several challenging issues pertaining to MST requiring VBA leadership's attention. Because VBA does not retain historical data on its denial decisions, OIG was unable to fully assess how often VBA denied male and female Veterans' disability claims and if VBA reversed its denials on appeal more frequently for male or female Veterans. In addition, most regional offices do not post signs informing Veterans about the services available through the Women Veterans Coordinators. Furthermore, many Women Veterans Coordinators and claims processors often felt unprepared to communicate effectively with Veterans who may be distressed or emotional during discussions regarding their MST-related disability claims. These regional office employees stated that additional training would be beneficial. Lastly, although VBA does provide some training on processing MST-related claims as part of its training on PTSD, it has not assessed the feasibility of requiring additional MST-related training and testing.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Under Secretary for Benefits

Completed 2011 Milestones

VA is addressing challenges with MST-related claims processing by using a multi-faceted approach. VA's Office of Mental Health Services provided sensitivity training to Women Veterans Coordinators on April 21, 2011, and this lesson, *Military Sexual Trauma Sensitivity Training,* was added to the Talent Management System on May 31, 2011.

VBA and the Under Secretary for Benefits brought a new focus on the processing of PTSD claims based on Military Sexual Trauma (MST).

- VBA incorporated sensitivity training into the 2011 National Training Curriculum mandatory training hours required for all claims processors. This mandatory curriculum includes a new MST training lesson created by VBA's Compensation Service and the *Military Sexual Trauma Sensitivity Training* lesson.
- In March 2011, signs were posted in all VBA regional offices to ensure that Veterans are aware of services and assistance provided by Women Veterans Coordinators. These coordinators case manage claims including assisting claimants in gathering the evidence necessary to decide their claims.
- In June 2011, VA's Under Secretary for Benefits issued a letter to all field personnel emphasizing the relaxed claims processing standards for MST claims.
- VBA's Compensation Service provided additional guidance in July 2011 instructing the field that corroborating evidence of a MST could be found on DD Form 2910, *Victim Reporting Preference Statement* and DD Form 2911, *Forensic Medical Report: Sexual Assault Examination* and similar forms.
- The Compensation Service drafted a new comprehensive training letter and plan for field personnel devoted to processing these claims.

Planned 2012 Milestones with estimated completion quarter

VBA will enhance the rating application used to prepare disability decisions so that historical data on denied claims are not overwritten by subsequent decisions. **(Q1)**

VBA will implement any process improvements identified during the review of claims denied for PTSD due to MST. **(Q1)**

OIG Sub-Challenge #2F: Timely Processing of Post 9/11 GI Bill Benefits Payments

VA continues to face major challenges managing the Post 9/11 GI Bill Program. The program was rapidly implemented in 2009 using interim software and an inexperienced, temporary workforce. VA was required to begin paying benefits for the *Post 9/11 Veterans Educational Assistance Act of 2008* in August 2009. The Post 9/11 GI Bill Program is substantially different from previously authorized VA education benefits programs, which provided one monthly payment to eligible claimants. The Post 9/11 GI Bill, in contrast, provides multiple payments to both claimants and schools. As such, VBA's existing information technology (IT) systems were not capable of processing this new benefit, and claims personnel needed comprehensive training.

Beginning in October 2008, VBA and Office of Information and Technology (OIT) initiated a joint project to develop an interim technology solution, which included new applications as well as modifications to several existing systems. The interim solution is not fully automated, requiring significant manual processing. As a result, VA was unable to process its fall 2009 education claims on time due to system limitations and inadequate staffing. In June 2010, the Department deployed Release 2 of the automated long-term solution for facilitating claims processing on schedule, with plans to convert records and train end users to use the system in July 2010. Additionally, in January 2011 President Obama signed into law the *Post – 9/11 Veterans Education Assistance Improvement Act* (G.I. Bill 2.0). The G.I. Bill 2.0 broadens the eligibility pool and increases the tuition and other benefits offered to claimants. To ensure new claimants and previous claimants, who decide to change their benefit elections, receive timely benefits, end users will need to become familiar with the eligibility requirements and increased benefits of the new law while also becoming familiar with the features of the new system.

VA's Program Response
Estimated Resolution Timeframe: 2013
Responsible Agency Official: Under Secretary for Benefits

Completed 2011 Milestones

In August 2009, VBA implemented the Post-9/11 GI Bill using interim manual procedures and processing tools. VA's long-term strategy to implement this benefit program is the development of an end-to-end information technology solution that utilizes rules-based, industry-standard technologies to modernize the delivery of Post-9/11 GI Bill benefits. VA's Long Term Solution (LTS) was scheduled to be released in five phases to provide incremental capability to the users in the regional processing offices. Release 1 of this effort was successfully deployed on March 31, 2010, and provided functionality to calculate new

original awards; automated calculation of awards including tuition and fees, housing, books and supplies, the Yellow Ribbon program, and Montgomery GI Bill-Active Duty and Reserve Educational Assistance program kickers; and automated calculation of awards for overlapping terms and intervals. Release 2, which was deployed on June 30, 2010, served as the foundation from which VBA retired the interim processing solution and automated the education benefits business processes. Release 3 was deployed October 30, 2010, and provided a school enrollment interface between our VA Online Certification program and the LTS. Release 4 deployed on December 20, 2010, and contained an interface to the Benefits Delivery Network payment system in order for the system to pre-populate the data and automate payments.

The enactment of Public Law (P.L.) 111-377, the Post-9/11 Veterans Educational Improvements Act of 2010, modified certain aspects of the Post-9/11 GI Bill. Some modifications include the types of training approved for benefits, tuition and fee payments, and eligibility under the Post-9/11 GI Bill. The enactment of this law has impacted the development of the LTS for processing Post-9/11 GI Bill claims and VA's ability to fully automate the delivery of benefits. On June 4, 2011, release 5.0 was deployed which included some of the mandated changes to the LTS system.

Planned 2012 Milestones with estimated completion quarter

VBA will complete development and deployment of 12 Post-9/11 GI Bill reports. **(Q1)**

The LTS release 5.1 will implement changes to the Post-9/11 GI Bill required by P.L. 111-377 and provide other automation support enhancements. **(Q1)**

A subsequent release will give the LTS capability to conduct automated end-to-end processing on some supplemental claims. **(Q3)**

VBA and the Office of Information and Technology have partnered to develop the LTS, and will continue to work together on further enhancements, including any required modifications to the existing payment interface.

OIG CHALLENGE #3: FINANCIAL MANAGEMENT

-Strategic Overview-

Sound financial management not only represents the best use of limited public resources, but also the ability to collect, analyze, and report reliable data on which resource use and allocation decisions depend. OIG oversight assists VA in identifying opportunities to improve the quality and management of VA's financial information, systems, and other assets.

OIG Sub-Challenge #3A: Achieving Financial Management System Functionality and Effective Financial Management Oversight

In FY 2010, VA received an unqualified ("clean") audit opinion on its consolidated financial statements and made significant progress by reducing the number of material weaknesses from four to one. During FY 2010, VA took sufficient corrective action to eliminate the financial management oversight material

weakness. The auditors downgraded two other material weaknesses, financial management system functionality and compensation, pension, and burial actuarial liabilities, to significant deficiencies. The remaining material weakness concerns IT security controls and is discussed in the Information Management section (OIG Challenge #5).

Concerning financial management system functionality, the auditors continued to identify system limitations related to year-end entries in VA's core general ledger system and with the retention of certain VBA data longer than 60 to 90 days. VA was not in substantial compliance with the *Federal Financial Management Improvement Act of 1996* due to this significant deficiency and the material weakness in IT security controls. In regards to the compensation, pension and burial actuarial liabilities, VA made significant progress in providing complete and accurate information to the actuaries but still needed to improve its related policies and procedures. The auditors also reported other significant deficiencies concerning accounts receivable resulting from advance payments under the Post 9/11 GI Bill, accounts payable, and intra-governmental reconciliations.

In April 2009, VA awarded a task order for the first phase of the SAM pilot project. However, OIG determined that FLITE program managers did not effectively plan for or manage the SAM pilot project. Specifically, FLITE program managers did not take well-timed actions to ensure VA achieved cost, schedule, and performance goals for the SAM pilot project and that the contractor provided acceptable deliverables in a timely manner. The FLITE program managers awarded the SAM pilot project task order at a time when the program suffered from significant staffing shortages. As a result, VA extended the SAM pilot project from 12 to 29 months, potentially doubling contract costs unnecessarily. Finally, VA delayed other FLITE acquisitions because of the lack of progress made on the SAM pilot project.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Executive in Charge, Office of Management
Assistant Secretary for Information and Technology
Under Secretary for Benefits
Under Secretary for Health

Completed 2011 Milestones

During 2011, VA focused on remediating the identified significant deficiencies and material weakness. VA's Office of Financial Process Improvement and Audit Readiness is responsible for managing, coordinating, and monitoring progress towards remediation. VA took positive action in 2011 to address the remaining five significant deficiencies. VA has addressed the financial management system functionality significant deficiency around "period 13," adjusting entries through system enhancements to VA's core financial management system (FMS) and developing policies and procedures to ensure all adjusting entries are maintained in FMS. VA has collected 84 percent of the accounts receivable resulting from advance payments under the Post 9/11 GI Bill. Remediation of the intra-governmental deficiency is comprised of two phases – system enhancements and reconciliation with trading partners, including working with VA's largest trading partners to reconcile data between the agencies. VA's remediation of the accounts payable significant deficiency includes working with the Administrations and staff offices to develop and implement standard operating procedures for recording, reviewing and monitoring accruals and accounts payable.

VA's OBO continued aggressive oversight of field compliance with financial policies and procedures. In instances of non-compliance, OBO identified root causes and made recommendations to the appropriate offices to correct deficiencies. In addition, OBO completed an assessment of internal controls over financial reporting in compliance with OMB Circular A-123. OBO identified deficiencies and issued recommendations. OBO will monitor all recommendations issued in 2011 until they are completed.

VBA finalized the BDN policies and procedures documentation providing standardized business practices for data reconciliation, transfer and storage of data, and external reporting. VBA automated the reporting function from the VBA data warehouse, resulting in more timely, accurate, and complete reports while reducing the risk of error associated with manual input. VBA completed the transfer of all BDN accounting data for Chapter 18 and Chapter 31 education benefits into the VBA data warehouse.

During 2011, OIT continued work on remediation of the IT Security Controls Material Weakness by developing enterprise-wide plans for remediation. In addition, with the assistance of such enterprise-wide initiatives as VA's Visibility to the Desktop Program, which allows visibility of all end-user computers connected to the VA network, VA has transitioned to continuous monitoring to provide a real time view of its security posture. This has already yielded positive results in Federal Desktop Core Configuration compliance. Vulnerability scanning of its network in 2011 has allowed VA to address, in real time, the continual and ever changing threats to its information systems.

In late February 2011, VA OIT senior management decided to place the SAM Project on OIT Program Management Accountability System (PMAS) 5-month strategic pause after the project received a third PMAS strike. A new business sponsor was brought onto the project team and it was decided to limit deployment functionality to support VA facilities management (FM) capabilities. The remainder of 2011 included a strategic re-planning of the project scope, project management and execution methodologies, business ownership, and deployment roadmap.

Planned 2012 Milestones with estimated completion quarter

VBA will complete the transfer of all BDN accounting data for Chapter 35 education benefits into the VBA data warehouse. **(Q1)**

OIT will execute the enterprise remediation plans developed in 2011 by individuals with the responsibility to implement the solution at their site or location. Many of OIT's 2011 corrective action plans include milestones that extend into 2012. Also, VA hopes to have its Visibility to the Server initiative fully in place by the 3rd quarter of 2012. This will allow visibility to the servers connected to its network and will allow VA to proactively remediate server-related vulnerabilities on a real-time basis. **(Q3)**

2012 will include a tactical project re-planning phase and a deployment phase for the SAM project. New methodologies will be refined and tailored for managing the project and the SAM solution. The planning phase will include the development of project deployment artifacts (e.g., implementation toolkit, standard FM processes, and standard configurations) that will be readily available and help with the end-user deployments as well as contribute to the overall plan for full enterprise deployment. Key

activities for site deployment will include business process reengineering, data migration, user training, system configuration, and initial production rollout of facilities' management's capabilities. **(Q4)**

During 2012, VA will continue to work toward complete remediation of any significant deficiencies and the remaining material weakness as well as continuing its aggressive oversight of field compliance with financial policies and procedures through regular reviews conducted by OBO as part of its 2012 Annual Review Plan. Identifying and reporting on non-compliance will assist field managers and VA Central Office in addressing the issues identified during field reviews, including systemic issues. **(Q4)**

OIG Sub-Challenge #3B: Reporting and Reducing Improper Payments

In November 2009, President Obama signed Executive Order 13520 with the purpose of reducing improper payments by intensifying efforts to eliminate payment error, waste, fraud, and abuse in major Federal programs. OIG found that VBA did not have an adequate process to ensure compliance with Executive Order 13520 reporting requirements. VA's listing of 101 high-dollar overpayments in the FY 2010 first quarter was incomplete primarily because VBA personnel misinterpreted reporting guidance. OIG identified 143 high-dollar overpayments totaling $623,434 that VBA did not report. An additional 39,208 potential high-dollar overpayments totaling $213 million were not adequately considered in VBA's process for identifying high-dollar overpayments. OIG determined that these 39,208 overpayments met some of the criteria used in determining reportable high-dollar overpayments. However, VBA did not gather and analyze additional information to determine which overpayments met all of the criteria and should have been reported.

OIG also found that VHA's FY 2009 risk assessment did not adequately assess the level of risk associated with their programs. VHA relied on a self-assessment process that consisted of a checklist; however, the process did not adequately address all payment components such as verifying the certification of the receipt of goods or services. A Financial Assistance Office review in 2009 found that claims were not adequately assessed for improper payment determination and concluded that risk assessment results were not valid.

To address these improper payments challenges, VA reported that VBA will review a statistically valid sample of all debts over $1,667 and report on those that meet the definition as written by the Office of Management and Budget (OMB), and include C&P and Education Service administrative errors in improper payment reporting. In addition, VHA will conduct formal risk assessments and reviews of all programs in FY 2011 (and at least once every 3 years thereafter), to include independent reviews with specialized checklists, to establish a new baseline and more accurately determine if VHA programs are susceptible to significant improper payments in accordance with the Improper Payments Elimination and Recovery Act of 2010.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Executive in Charge, Office of Management
Under Secretary for Health
Under Secretary for Benefits

Completed 2011 Milestones

During 2011 the Office of Management (OM) worked closely with the VHA and VBA to ensure compliance with Executive Order 13520, *Reducing Improper Payments*. As the liaison between the administrations, staff offices, and the Office of Management and Budget (OMB) relative to improper payments' policy and procedures, OM coordinated and oversaw VA's efforts to implement new and revised legislation based upon OMB guidance and ensured that consolidated VA reports to Congress and OMB were prepared in compliance with reporting requirements.

In the 3rd quarter of 2011, VBA began reviewing a statistically valid sample of all debts over $1,667. The sample was selected based on a 95-percent confidence rate with an uncertainty level of 5 percent. VBA used the results of the sample to develop inferential statistics regarding the population of debts. VBA reported on those payments that meet OMB's definition of improper payments in response to OIG Audit of VA's Implementation of Executive Order 13520, "Reducing Improper Payments." VBA will continue to report on improper payment cases where no receivable was established under the administrative error provisions. These reports contain root causes of debts, total number and amount of debts established in each quarter, and total amount of collections in each quarter.

VHA implemented significant improvements to its program risk assessments and reviews required by the Improper Payments Elimination and Recovery Act of 2010 (IPERA). Specifically, VHA conducted formal risk assessments on all 25 VHA programs. Risk assessments were completed by the VHA Financial Assistance Office (FAO) with input from program management. Based on the risk assessment results, medium and high risk programs that were probably or highly likely to be susceptible to significant improper payments underwent a statistically valid payment review. The VHA FAO reviewed sampled payments using a specialized checklist detailing specific compliance criteria to more accurately identify payment accuracy. For example, each sampled payment was reviewed against policies and procedures to determine if the payment was made to an eligible recipient, was for an eligible good or service, was a duplicate payment, was for goods or services received, accounted for credit of applicable discounts, was made in the correct amount, and was made in compliance with policies and procedures. In addition, for high risk programs, program officials were identified and are responsible for implementing a corrective action plan to strengthen internal controls, reduce improper payments, and establish reduction targets.

Planned 2012 Milestones with estimated completion quarter

OM is working with the Office of Acquisitions to develop the necessary solicitation documents for a GSA Schedule contract that will provide analysis of improper benefit payments data to determine the level of preventable improper payments under current laws, regulations, and policies. In addition, the contract will determine if it is feasible to pursue payment recapture audits of improper payments under IPERA.

The contract is expected to be awarded in the first quarter of 2012. **(Q1)** Based on the analysis provided, OM will continue work with VA administrations and offices to further reduce VA improper payments. **(Q4)**

VHA management has implemented the corrective actions recommended by OIG. VHA will continue to monitor and review its risk assessment and review process and make improvements where appropriate to further identify and reduce improper payments. **(Q1-4)**

OIG Sub-Challenge #3C: Improving Oversight of VA Workers' Compensation Program

VA continues to experience challenges with managing Workers' Compensation Program (WCP) cases effectively. VA's WCP costs have increased 44 percent over the last two decades to approximately $182 million, and VHA comprises 93 percent of the Department's total WCP costs. A 2011 OIG audit found that VHA submitted employee compensation forms timely, but lacked the medical evidence necessary to support the employee's continued disabilities. OIG's audit also identified missed opportunities to return employees to work, incomplete case file documentation, and instances of potential fraud.

OIG attributed these issues to a lack of oversight to ensure compliance with WCP statutory requirements. Additionally, VHA has not assigned dedicated WCP resources to manage cases effectively. Ineffective WCP case management could lead to program fraud, as well as potentially unnecessary and inappropriate costs to the Department. OIG recommended ensuring adequate oversight and assigning dedicated resources to assist VHA in improving its WCP case management.

Four prior WCP audits similarly reported enhanced case management could reduce the Departments' costs and the risk for fraud and abuse. For example, a 2004 audit reported VA lacked the medical evidence necessary to support the employee's continued disabilities and identified instances of potential fraud. OIG recommended VA increase Department-wide program management and oversight processes, and dedicate resources to ensure effective case management and reduce the risk of WCP fraud.

VA's Program Response
Estimated Resolution Timeframe: 2013
Responsible Agency Official: Under Secretary for Health
Assistant Secretary for Human Resources and Administration

Completed 2011 Milestones

The Department of Veterans Affairs (VA) acknowledges that oversight of its Workers' Compensation Program (WCP) and compliance with WCP statutory requirements must improve.

In April 2011 VHA began to develop an action plan to address how best to ensure employees return to work if that is possible, document case files completely, and reduce the potential for fraud.

VHA has identified operations resources, including personnel, to work with policy officials in VA and VHA to review and identify how best to improve existing procedures as well as implement new processes.

Planned 2012 Milestones with estimated completion quarter

VHA will:

- Establish clear reporting lines with delegated authority for identifying and implementing enforcement and compliance criteria for WCP including development and implementation of oversight and enforcement processes. **(Q1)**
- Issue instructions to improve accuracy of case management in the field. **(Q2)**
- Monitor performance to identify areas that require additional focus and improvement. **(Q4)**
- Establish criteria using best practices and return-on-investment models to determine what is an appropriate WCP staff/programs ratio to manage a WCP effectively and efficiently. **(Q4)**
- Collaborate with appropriate VA offices. **(Q1 and ongoing)**

OIG CHALLENGE #4: PROCUREMENT PRACTICE

-Strategic Overview-

VA operations require the efficient procurement of a broad spectrum of services, supplies, and equipment at the local and national level. OIG audits, inspections, and reviews continue to identify systemic deficiencies in all phases of the procurement process to include planning, solicitation/negotiation/award, and administration. OIG attributes these deficiencies to the decentralized organizational structure in addition to inadequate oversight and accountability.

Deficiencies in the procurement process, failure to comply with the Federal Acquisition Regulation (FAR) and VA Acquisition Regulation, and the lack of effective oversight increase the risks that VA will award sole source and set-aside contracts intended for eligible Veteran-owned and service-disabled Veteran-owned businesses (VOSB and SDVOSB) to ineligible businesses and that contractual performance requirements will not be met. Further, VA risks paying more than fair and reasonable prices for supplies and services and making overpayments to contractors. VA must improve its acquisition processes and oversight to restore the integrity of VA's VOSB and SDVOSB programs and ensure the efficient use of VA funds and compliance with applicable procurement laws, rules, regulations, and policies.

OIG Sub-Challenge #4A: Improve Oversight for VA's VOSB and SDVOSB Programs

OIG's audit of Veteran-owned small business (VOSB) and of service-disabled Veteran-owned small business (SDVOSB) programs disclosed that VA awards numerous VOSB and SDVOSB contracts annually to ineligible businesses. Businesses were ineligible because Veterans did not really own and control the businesses or the Veteran owners subcontracted more work to non-Veteran-owned businesses than allowed under Federal regulations. Ineligible businesses received contract awards due to inadequate business verification processes and program controls and the lack of a coordinated VA acquisition oversight process to ensure contracting officers assessed contractor eligibility at the time of award. Strengthened management controls and oversight for the VOSB and SDVOSB contracting programs could reduce awards made to ineligible businesses by at least $500 million or $2.5 billion over the next 5 years. OIG projections also indicate that VA's reported total VOSB and SDVOSB procurement dollars

could be overstated anywhere from 3 to 17 percent due to awards made to ineligible businesses. Thus, VA may be barely meeting the Secretary's VOSB and SDVOSB procurement goals of 12 and 10 percent, even though it reported its VOSB and SDVOSB awards totaled 23 and 20 percent, respectively, of its procurement dollars in FY 2010.

The OIG has 86 open SDVOSB investigations and has issued 268 subpoenas and executed 19 search warrants. To date, OIG investigations have resulted in six indictments and one conviction. In April 2011, the CEO of a construction management and general contracting company that was awarded VA and Department of the Army construction contracts set aside for SDVOSB and VOSB companies was convicted of committing Major Fraud Against the United States, Witness Tampering, False Statements, and Mail Fraud. A joint OIG investigation revealed that the CEO falsely self-certified that his company was an eligible SDVOSB and VOSB in order to obtain over $16 million in contracts that were set aside for legitimate SDVOSBs and VOSBs. Both the CEO and the company have been debarred from doing business with the Government for 5 years.

In June 2011, a company and four individuals were charged with Conspiracy to Defraud the Government, Major Program Fraud, Wire Fraud, Conspiracy to Commit Money Laundering, and False Statements. A joint OIG investigation determined that the SDVOSB acted as a pass-through company for a larger company and that the owner of the SDVOSB was not a service-disabled Veteran. Subsequent to the indictments, agents arrested the four individuals and simultaneously executed eight search/seizure warrants. Based on information provided by VA OIG, the Department's Suspension and Debarment Committee suspended the company and the four individuals from doing business with the Federal Government.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Executive Director, OSDBU

Completed 2011 Milestones

On September 4, 2011, VA completed the verification of all firms in the Vendor Information Pages (VIP) database, eliminating the need for the expedited Class Deviation program that ensured that all VOSBs were verified prior to receiving an award under the "Veterans First" procurement program. VA has implemented and continues to monitor contracting actions for opportunities suitable for Veteran small firms. We have re-engineered the process to include a full document review and have expanded our site visit program. Additionally, VA has become more proactive through improved communications to our stakeholders about the status of their applications, performing a detailed records check to ensure that all applications are properly accounted for and recorded, and implementing a new quality control process to give better management oversight to the program.

For cases of misrepresentation, Public Law 109-461 directs VA to debar SDVOSB or VOSB firms for up to 5 years. VA has implemented this provision and initiated debarment proceedings for 13 firms and individuals. In September 2010, VA established the 8127 Debarment Committee, so named after section 8127 of title 38, United States Code, as adopted in Public Law 109-461. The 8127 Debarment Committee has provided guidance on the VA Web site on when and how to refer cases to them for

review. The Committee makes recommendations to the agency debarring official, the Deputy Assistant Secretary for Acquisition and Logistics. If a firm is debarred, VA makes an entry in the Governmentwide Excluded Parties List System (EPLS). The Federal Acquisition Regulation (FAR) directs contracting officers to consult the EPLS (and document to the contract file) prior to making a contract award to ensure debarred firms do not receive contracts during the period of the debarment. In cases of clear intent of misrepresentation, referrals are made to the Office of the Inspector General. Additionally, OIG maintains a hotline that accepts complaints from VA employees and the general public concerning criminal activity, waste, fraud, abuse, and mismanagement involving VA programs and operations.

Performance fraud is a serious potential risk to the integrity of the program as it becomes another way ineligible firms might tap into the program using eligible firms as fronts. VA's Office of Acquisition, Logistics, and Construction is heightening its scrutiny. We will begin sampling contracts and reviewing them for compliance as well as reviewing contracts whenever instances of alleged fraud have taken place. OSDBU also monitors and reviews status protests and will monitor the subcontracting compliance reviews.

Planned 2012 Milestones with estimated completion quarter

In addition to the above ongoing activities, VA has established a Subcontracting Compliance Review Program and will be auditing selected contracts to ensure prime contractors are meeting subcontracting obligations. **(Beginning in Q1)**

OIG Sub-Challenge #4B: Improve Oversight of Procurement Activities

VA does not have a comprehensive national program to oversee contracting and purchasing activities, especially at the local levels. This is due to the decentralization of the process and the failure of VA entities with dedicated contract specialists to establish an oversight program. Effective oversight is difficult to achieve because there is no central database that captures all VA contracting and purchasing information. Although VA established Electronic Contract Management System (eCMS) in 2007, OIG has found that it does not capture all VA procurement information and therefore does not provide accurate and complete information. A 2009 audit reported that eCMS was far from a complete inventory of procurements, in part because it only required data for procurements over $25,000. OIG also found that only an estimated 17 percent of procurement actions required to be recorded were actually recorded. Recent reviews indicate that the deficiencies still exist.

For example, an OIG audit concluded managers at VA's National Acquisition Center (NAC) did not ensure staff fully utilized VA's mandatory eCMS to develop and award national contracts. This occurred because the Office of Acquisition and Logistics provided limited oversight to monitor eCMS compliance and ensure eCMS capabilities adequately supported NAC operations. In addition, Office of Acquisition, Logistics, and Construction (OALC) and NAC officials impaired and diminished visibility of VA procurement actions by not ensuring compliance with the mandatory use of eCMS.

During OIG's Recovery Act oversight, eCMS data reliability and system problems were identified that impact OALC's ability to effectively oversee VA procurements. VHA contracting officers did not uniformly and consistently use eCMS, did not always upload required contract documentation to eCMS,

did not always correct known inaccuracies in eCMS contract data, and sometimes misidentified contracts in the system. OALC officials had not formally alerted VHA contracting officers at the time of OIG's review of an eCMS technical interface problem related to the posting of solicitations on the Federal Business Opportunities website. These systemic problems affect the visibility of all VA procurement actions in eCMS and weaken the effectiveness of VA procurement oversight processes that rely on eCMS contract information.

Another OIG review of the Interagency Agreement between VA and the Navy, Space and Naval Warfare Systems Center (SPAWAR) for the award and administration of task orders for the Replacement Scheduling Activity development program, determined that contracts awarded by third parties like SPAWAR and the General Services Administration are not captured in eCMS. In addition, purchase card transactions are not included.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Executive Director, Office of Acquisition, Logistics, and Construction

Completed 2011 Milestones

OALC expanded the requirement for procurement data in eCMS to include actions equal to or greater than $3,000 (formerly $25,000). OALC collects and tracks monthly strategic metrics for eCMS usage, compliance, and availability. Quarterly Independent Validation and Verification (IV&V) of agency Federal Procurement Data System (FPDS) records against eCMS Contract Action Reports (CARs) enables VA to track and remediate data accuracy and completeness issues through continuous reporting, training, and enforcement. The NAC ensures all new procurements valued at the micro-purchase level (currently $3,000) or more are accomplished in eCMS. NAC contracting officers are populating eCMS with complete, accurate information.

VA's Acting Chief Acquisition Officer and Senior Procurement Executive sponsored a procurement conference in June. It was attended by over 700 acquisition professionals from organizations throughout VA.

VA successfully conducted five A-123 reviews at the Technology Acquisition Center, Construction and Facilities Management, and three VHA regional contracting offices. VA led an Integrated Process Team in developing 11 enterprise-wide performance metrics that are being used to assess procurement outcomes across the Department. VA is in the process of finalizing the development of distance learning alternatives for the acquisition workforce.

VA has implemented a formal certification program for Program/Project Managers in accordance with the Federal Acquisition Program.

Planned 2012 Milestones with estimated completion quarter

OALC will place increased focus on tracking and reporting Interagency Agreements (IAA) in eCMS to ensure delivery and milestone target dates are met and to provide greater visibility and oversight of all VA procurement actions. Purchase card transactions are not processed through eCMS when the dollar amounts fall below VA's $3,000 threshold requirement. **(Q4)**

OIG Sub-Challenge 4C: Effective Contract Administration

OIG continues to identify poor contract administration as a systemic deficiency resulting in overpayments to vendors. OIG's national audit of FY 2009 VA patient transportation contracts disclosed that Contracting Officer's Technical Representatives (COTRs) did not ensure the accuracy of related invoice payments. Payments for 18 percent of the trips on the patient transportation invoices were inaccurate because COTRs did not adequately review invoices before certifying them for payment, unauthorized staff verified and certified invoices instead of the designated COTR, and performance plans did not hold COTRs accountable for the performance of collateral COTR duties. Improved VISN patient transportation contract monitoring could prevent a projected $91.8 million in overpayments and $6.5 million in underpayments over the next 5 years.

An OIG inspection of brachytherapy services at the Philadelphia, PA, VAMC identified numerous deficiencies in the procurement of radiation therapy services from the University of Pennsylvania. OIG found that the COTR approved invoices for engineering services that were not included in the contract and did not independently verify that the services were provided. Instead, the COTR relied on verification by individuals who worked for the contractor. Furthermore, inspections of contracts awarded for services at CBOCs repeatedly found that COTRs failed to ensure that contractors complied with performance measures or off-set payment as required under the provisions of the contract. OIG also found that COTRs failed to timely disenroll patients as required under the terms of the contracts, which resulted in overpayments.

Collectively, OIG audits, inspections, and reviews have shown that COTRs are often poorly trained regarding their duties and responsibilities, are frequently not familiar with the terms and conditions of the contract, and may not be able to devote adequate time to the administration of the contract because it is a collateral duty.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Executive Director, Office of Acquisition, Logistics, and Construction

Completed 2011 Milestones

VHA released the COTR SOP in May 2011. The COTR SOP includes instructions on when a COTR is required, training requirements, nomination procedures, sample COTR designation letters, record-keeping requirements, invoice procedures, and the responsibilities of the Contracting Officer and COTR.

VHA Procurement Operations has also established a COTR Management Program that includes a newsletter and file review program.

The VA Acquisition Academy (VAAA) had two milestones to improve COTR training. The VAAA exceeded its goal to train over 900 additional COTRs with in-person training by reaching 1,958 with a 91 percent student overall satisfaction score. Additionally, the VAAA had a milestone to develop a distance delivery COTR course in 2011. That milestone was placed on hold based upon the Federal Acquisition Institute's (FAI) impending re-design of the COTR certification and training requirements. FAI will establish a new three-level FAC-COTR certification and training program based on the contract complexity. To mitigate the lack of distance delivery capability, the VAAA delivered COTR training at all VISN locations. This increased the accessibility of the training to VA's COTRs and minimized the travel costs.

VA's Office of Business Oversight (OBO) continued oversight of VHA field compliance with Contract Administration Payment Accountability policies and procedures. In instances of non-compliance, OBO identified the root causes and made recommendations to VHA senior officials to correct deficiencies. OBO will monitor all recommendations issued in 2011 until they are completed.

Planned 2012 Milestones with estimated completion quarter

The VHA Procurement Operations COTR Management Program intends to fully implement the COTR File Review program in 2012. VHA anticipates completing six COTR audits in 2012. The audits will be completed VISN by VISN. The COTR SOP includes additional VHA training for VHA COTRs. The VHA Operations training officer will develop a COTR training implementation plan and ensure completion of the supplemental VHA COTR training upon approval by VHA management. The COTR supplemental training module has been completed and is ready for distribution. **(Q4)**

VA will continue oversight of VHA field compliance with Contract Administration Payment Accountability policies and procedures through regular reviews conducted by OBO as part of its 2012 Annual Review Plan. Identifying and reporting on non-compliance will assist VHA senior officials in addressing the issues identified during field reviews, including systemic issues. **(Q4)**

OIG Sub-Challenge #4D: Compliance with Laws and Regulations

For several years, OIG audits and reviews have identified VA challenges in complying with Federal and VA acquisition laws and regulations that protect the Government's interests and promote transparency in procurements. Most recently, during a 2011 OIG audit, OIG concluded that many contracts in VA's VOSB and SDVOSB programs did not meet FAR, VA Acquisition Regulation (VAAR), and VA contracting requirements. Sixty-eight percent of 79 VOSB and SDVOSB contracts valued at $21.9 million had one or more contracting deficiencies. Contracting officers awarded 20 businesses 30 VOSB and SDVOSB contracts valued at $12 million where they did not complete a justification for other than full and open competition (JOTFOC) prior to the award or perform and document a price reasonableness determination in a document such as the price negotiation memorandum (PNM). Contracting officers also did not review the Excluded Parties List System (EPLS) to ensure businesses had not been debarred or determined ineligible to receive the contracts. Contracting officers did not check the EPLS for 23 businesses prior to the award of 41 VOSB and SDVOSB contracts totaling $19.5 million. To meet this

challenge, VA needs to strengthen the monitoring of VOSB and SDVOSB contracts to ensure contracting officers have complied with applicable FAR and VAAR.

An OIG audit of VA transportation contracts found that contracting officers did not always award patient transportation services contracts competitively and contract files did not include all documentation required by the FAR. OIG determined there were systematic failures by VISN contract managers to adequately review the contracts, identify deficiencies, make recommendations for improvement, and monitor corrective actions.

In 2010, OIG reviewed allegations relating to the award of contracts to a company established by a former VA employee and found that VA personnel awarded contracts without complying with the Competition in Contracting Act. The task orders were issued against an existing multiple award contract without complying with the competition requirements of the underlying contract. In addition, the requirement of certain task orders was outside the scope of the contract. These findings are consistent with OIG reports issued in 2008 and 2009.

Pre and postaward reviews of contracts awarded by VA's National Acquisition Center (NAC) under Federal Supply Schedule (FSS) 621 I, Professional and Allied Health Care Staffing Services, found awarded prices at the contract level were not fair and reasonable as required by applicable laws and FAR provisions for the FSS program. OIG also found that the methodologies used by VA contracting officers to determine contract pricing were inadequate. Although NAC contracting officials knew that the prices were the "worst case" prices and not fair and reasonable prices, they failed to issue policy or advice to purchasing entities, which resulted in purchasers paying more than fair and reasonable prices for these services.

A related national audit of purchases made against FSS 621 I contracts for health care services disclosed that VA personnel at the buying level did not comply with FAR and internal VA policy regarding the purchase of supplies and services from the FSS. VISN contracting officers paid higher than necessary labor rates and travel expenses because they did not adequately review the orders' prices and did not always ensure adequate competition or maximum use of the FSS contracts, or maintain required contract documentation for orders. OIG also found that some medical facility personnel made unauthorized commitments when purchasing from these FSS contracts.

The lack of FSS procurement purchasing policies and procedures makes health care staffing service orders vulnerable to higher than fair and reasonable prices, improper payments, and violations of FAR requirements. Actions needed to strengthen FSS health care services price evaluation and ordering practices could reduce VHA costs by approximately $7.7 million annually, or $38.5 million over the next 5 years.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Executive Director, Office of Acquisition, Logistics, and Construction

Completed 2011 Milestones

eCMS automatically checks the Excluded Parties List System (EPLS) for excluded vendors and notifies the Contracting Officer (CO) if the vendor selected in eCMS is on the EPLS exclusion list. eCMS also retains a history file of the EPLS search. eCMS integrated EPLS in 2010. As a result, OALC automatically checks for excluded vendors, captures the history of the search, and provides COs with data permitting them to make informed vendor decisions for selections. There is no additional action planned other than reporting.

VHA has improved its oversight programs. The Integrated Oversight Process contract reviews have shown that VHA generally completed contracts in accordance with acquisition laws, regulations, and VA policy. VHA established an Acquisition Quality Office to provide the VHA Procurement and Logistics Office comprehensive insight into VHA's Acquisition Program. The audits focus on four primary areas: (1) Organizational Management, (2) Human Capital, (3) Acquisition Planning and Information Management, and (4) Basic Contract Reviews. The Acquisition Compliance audit team completed seven audits in 2011. Each VISN and Service Area Office (SAO) will be audited once every 3 years. In addition to the audit program, the Acquisition Quality office completed several standard operating procedures (SOPs) to improve the oversight of procurement activities in areas such as Integrated Oversight, Other Than Full and Open Competition, Procurement Process, Responsibility Determination, and contract closeout. VHA also established Quality Assurance/Compliance positions at the SAO and VISN levels to assist with the integrated oversight review process and implement the SOPs. To increase oversight activities, VHA also added metrics to the dashboard metric program.

The NAC formed a workgroup that includes members of the VA OIG, NAC, General Service Administration, VHA, and other policy offices. Currently the group is reviewing two proposals that outline updates to the commercial sales practice disclosures to provide a better understanding of the commercial pricing strategies used by FSS vendors. This will ensure adequate fair and reasonable determinations can be completed by COs.

VA completed five A-123 reviews of the Technology Acquisition Center, Construction and Facilities Management, and three VHA regional contracting offices.

Planned 2012 Milestones with estimated completion quarter

OALC is conducting eCMS stakeholder sessions to collect change requests. If OALC collects and validates additional data requirements for VOSB and SDVOSB contracts, OALC will implement the requirements in future eCMS releases. **(Q4)**

VHA will continue to implement the Acquisition Quality audit program and plans to complete ten audits in 2012 with approximately 3 to 4 audits completed each quarter. The SAOs/VISNs will be monitored for

compliance with the Integrated Oversight SOP. VHA is working to establish compliance metrics for Contract Review Board level contract reviews. Initial compliance reports should be available at the end of the first quarter. **(Q4)**

The NAC will use recommendations from the workgroup mentioned above to improve the overall functioning of the 621i Professional and Allied Supplemental Staffing contracts. **(Q4)**

OIG CHALLENGE #5: INFORMATION MANAGEMENT
-Strategic Overview-

Information technology (IT) should enable government to better serve its citizens. The Federal Government, however, has experienced difficulty in achieving productivity improvements from IT advances similar to those realized by private industry. In large part, this has been caused by poor management of large-scale IT projects. All too often, Federal IT projects run over budget, behind schedule, or fail to deliver promised functionality.

VA has consolidated the vast majority of its IT resources under the Chief Information Officer (CIO) by reorganizing the IT functions of VA's Administrations under OIT. Through the stewardship of the CIO, OIT has positioned itself to facilitate VA's transformation into a 21st century organization by focusing on five key management areas. In 2011, OIT strived to: (1) achieve customer service in all aspects of IT; (2) develop a next generation IT Security Plan; (3) manage its IT organizations with metrics that are tracked; (4) focus on product delivery using the Project Management Accountability System (PMAS); and (5) perform better overall financial reporting.

However, OIG's annual CFS and information security program audits continue to report IT security control deficiencies that place sensitive information at risk of unauthorized use and disclosure. Furthermore, OIG oversight work indicates that additional actions are needed to safeguard and effectively manage VA's information resources and data, and that VA has only made marginal progress toward eliminating the information management material weakness reported in the CFS audit and remediating major deficiencies in IT security.

OIG Sub-Challenge #5A: Development of an Effective Information Security Program and System Security Controls

OIG continues to identify major IT security deficiencies in the annual information security program audits. While VA has made progress defining policies and procedures supporting its agency-wide information security program in accordance with the *Federal Information Security Management* Act (FISMA), they face significant challenges in meeting the requirements of FISMA.

OIG's 2010 audit identified significant deficiencies related to access, configuration management, and change management controls. Improvements are needed in service continuity practices to prevent unauthorized access, alteration, or destruction of major application and general support systems. CFS auditors also concluded that a material weakness exists related to the implementation of VA's agency-wide information security program. Finally, VA has also identified over 15,000 system security risks and

corresponding Plans of Action & Milestones (POA&M) that need to be remediated to improve its overall information security posture.

VA needs to focus its efforts to: (1) dedicate resources to aggressively remediate the significant number of unresolved POA&Ms and focus resources on addressing high risk system security deficiencies and vulnerabilities; (2) implement mechanisms to identify and remediate system security weaknesses on the Department's network infrastructure, database platforms, and web application servers across the enterprise; (3) develop and establish a system development and change control framework that will integrate information security throughout each system's life cycle; (4) implement technological solutions to actively monitor all network segments for unauthorized system access to Department programs and operations; and (5) implement mechanisms to ensure that system contingency plans are fully tested in accordance with FISMA.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Director, IT Operations and Deputy Assistant Secretary for Security

Completed 2011 Milestones

VA continued to make progress in improving its information security posture in 2011. This has resulted in a more comprehensive security program that better protects sensitive information. In 2011, VA improved its controls over remote access to its systems and information by continuing to eliminate the use of the One VA Virtual Private Network (VPN). Remote users are now required to use VA's RESCUE software to connect to its network; RESCUE assesses and corrects system configurations and scans for malware upon connection. Ninety percent of VA's One VA VPN remote users have been transitioned to VA's RESCUE software for remote network connectivity. Vulnerability scanning was also performed in 2011 to allow VA to address, in real time, the continual and ever changing threats to its information systems. During 2011, VA continued work on remediation of the IT Security Controls Material Weakness by developing enterprise-wide plans for remediation. VA has transitioned to continuous monitoring to provide a real-time view of its security posture. This has already yielded positive results in Federal Desktop Core Configuration (FDCC) compliance.

Planned 2012 Milestones with estimated completion quarter

With the assistance of enterprise-wide initiatives such as VA's Visibility to the Desktop and Server Programs, VA will have visibility into 100 percent of its servers and desktops by 2012 **(Q3)**. This will allow visibility of all end user computers and servers connected to the VA network so that VA can proactively remediate vulnerabilities on a real time basis. VA will continue to execute the enterprise remediation plans developed in 2011 for its IT Security Controls Material Weakness by individuals with the responsibility to implement the solution at their site or location. Many of VA's 2011 corrective action plans include milestones that extend into 2012 **(Q4)**.

OIG Sub-Challenge #5B: Strengthening Information Technology Governance

A 2009 OIG audit determined that the ad hoc manner in which OIT managed VA's realignment of its IT program from a decentralized to a centralized management structure inadvertently resulted in an environment with inconsistent management controls and inadequate oversight. Although OIG conducted this audit more than 2 years after VA centralized its IT program, senior OIT officials were still working to develop policies and procedures needed to manage IT investments effectively in a centralized environment. For example, OIT had not clearly defined the roles of IT governance boards responsible for facilitating budget oversight and IT project management.

Further, in September 2009, OIG reported that VA needed to better manage its major IT development projects, valued at that time at over $3.4 billion, in a more disciplined and consistent manner. In general, OIG found that VA's System Development Life Cycle (SDLC) processes were adequate and comparable to Federal standards. However, OIT did not communicate, comply with, or enforce its mandatory software development requirements. OIT did not ensure that required independent milestone reviews of VA's IT projects were conducted to identify and address system development and implementation issues. Once again, OIG attributed these management lapses to OIT centralizing IT operations in an ad hoc manner, leaving little assurance that VA was making appropriate investment decisions and best use of available resources. Moreover, VA increased the risk that its IT projects would not meet cost, schedule, and performance goals, adversely affecting VA's ability to timely and adequately provide Veterans health services and benefits.

These audits demonstrated that OIT needed to implement effective centralized management controls over VA's IT investments. Specifically, OIG recommended that OIT develop and issue a directive that communicated the mandatory requirements of VA's SDLC process across the Department. OIG also recommended that OIT implement controls to conduct continuous monitoring and enforce disciplined performance and quality reviews of the major programs and projects in VA's IT investment portfolio. Although OIT concurred with recommendations and provided acceptable plans of actions, OIT's implementation of the corrective actions is still ongoing. For example, OIT is reviewing for approval the draft governance board charters and plans to issue a VA directive mandating Program Management Accountability System (PMAS) compliance once version 3.0 of the guide is developed. PMAS is VA's new IT management approach that focuses on achieving schedule objectives while the scope of functionality provided remains flexible.

As of May 2011, OIT was managing all 119 active development programs and projects using PMAS. An additional 60 projects were in the planning stage, while 41 projects were classified as new starts. However, OIT lacks the program management skills and the financial management system capabilities to fully track program costs and to implement an effective earned value management system to assist with achieving cost and performance goals. VA is challenged to ensure appropriate investment decisions are made and that annual funding decisions for VA's IT capital investment portfolio will make the best use of VA's available resources.

VA's Program Response
Estimated Resolution Timeframe: 2012
Responsible Agency Official: Assistant Secretary for Information and Technology

Completed 2011 Milestones

OIT continues to make significant progress towards strengthening IT governance through the effective use of three IT governance boards that provide Departmental IT direction, oversight, prioritization, enforcement, and issue resolution. All VA administrations and staff offices are represented to ensure their critical business requirements are understood. The Department's Strategic Management Council (SMC) is chaired by the VA Deputy Secretary and serves as the conduit for directly linking the three IT governance boards. The SMC makes decisions related to IT strategy and technology, overall level of IT spending, aligns and approves enterprise architecture, accepts IT risks, and is the final approver of matters that come before the SMC.

The three IT governance boards are assigned specific focus areas to effectively address and manage both near-term and long-term IT requirements and resources. The Programming and Long Term Issues Board (PLTIB) focuses on long-term multi-year program planning which leads into the budget formulation and execution year activities that the Business and Near Term Investment Board (BNTIB) is responsible to oversee. Transparency, collaboration, and continuity play a vital role in effective governance of IT programs. Toward this end, the implementation of vertical and horizontal coordination, reporting, and information flow between the PLTIB and the BNTIB has been achieved (2011) and will be maintained. The Information Technology Leadership Board adjudicates inter- and intra-board issues of significance that cannot be resolved between or within the respective boards as well as making final IT recommendations to the SMC.

To support VA's commitment to transform the Department into a 21st Century organization, the new Office of Architecture, Strategy and Design (ASD) oversees statutorily required processes and outcomes and is a key component of OIT's strategic planning, IT governance, and policy and process development. ASD creates standards for implementing IT solutions that best serve Veterans while exercising proper stewardship of resources. ASD provides a framework of policies, guidance, and governance to ensure IT programs and projects are designed and executed to satisfy current and future business needs of VA. This office helps ensure work performed by OIT meets customer demand by establishing a framework which integrates technical, business, and data architecture; provides systems design and integration; creates forward thinking IT strategy; and uses knowledge management to provide methods and technology to acquire and retain knowledge to improve information sharing across OIT and its customers.

Additionally, ASD establishes processes and practices to enable success of VA IT programs and projects by providing accountability and transparency controls in PMAS. Used as a complementary piece to VA's IT governance process, PMAS has proved invaluable in the early identification of underperforming IT investments, thereby providing the Assistant Secretary for Information Technology the flexibility to reallocate scarce resources to projects that are on track to succeed and provide a significant value to

Veterans, their dependants, survivors, and other stakeholders. A complete description of 2011 PMAS milestones can be found in the response to OIG Sub-challenge #5C.

Planned 2012 Milestones with estimated completion quarter

OIT will continue to mature IT Governance Board processes and methodologies **(Q2)**. A complete description of 2012 PMAS milestones can be found in the response to OIG Sub-challenge #5C.

OIG Sub-Challenge #5C: Effective Oversight of Active IT Investment Programs and Projects

VA has a longstanding history of challenges in effectively managing IT development projects. For example, after 6 years and despite spending more than $249 million, VA halted the Core Financial and Logistics System (CoreFLS) project in 2004 due to significant project management weaknesses. VA began work on the Financial and Logistics Integrated Technology Enterprise (FLITE) program, the successor to CoreFLS, in September 2005 to meet its ongoing need to address a material weakness in VA's financial operations. In July 2010, VA canceled FLITE, with the exception of the Strategic Asset Management (SAM) project, partly because FLITE had suffered from the same project management issues that plagued CoreFLS. SAM subsequently proved to be another troubled IT development project. In April 2009, VA awarded a task order for the SAM project valued at approximately $8 million. Modifications increased the value of the task order to over $20 million, more than doubling the value of the task order and the period of performance. Then, in February 2011, VA suspended SAM for failing to meet three delivery milestone dates.

Similarly, the Veterans Service Network (VETSNET) program has faced a number of cost, schedule, and performance goal challenges. As of May 2009, VBA estimated the total cost of VETSNET to be more than $308 million; more than 3 times the initial cost estimate. After more than 14 years of VBA development, including management and process improvements, VETSNET has the core functionality needed to process and pay the majority of compensation and pension (C&P) claims; however, work remains to meet the original goals for VETSNET. VETSNET's major releases were developed with unstable functional requirements resulting in inadequate time to fully test software changes. Test environments did not always sufficiently replicate production environments resulting in inadequate testing of VETSNET software releases.

Major releases of VETSNET contained functions that did not operate as intended and many system defects were deferred or corrected in subsequent software releases. In addition, VA also has not communicated a clear and consistent long-term objective for the VETSNET program. VETSNET is expected to replace only the legacy C&P functions; however, VETSNET's Exhibit 300 and VA's FY 2011 Budget Submission state that VBA will retire the entire legacy system in FY 2012, due to VETSNET enhancements. Further complicating matters, VBA has recently launched several high profile IT initiatives that will leverage VETSNET to make benefit payments. These overlapping IT initiatives increase the risks that VBA will experience further delays in achieving the original VETSNET goals.

Recently, VA has also had trouble establishing an effective IT project management system. A 2011 OIG audit found a great deal of work remains before VA's PMAS can be considered completely established and fully operational. PMAS represents a major shift from the way VA historically has planned and

managed IT development projects. PMAS was designed as a performance-based management discipline that provides incremental delivery of IT system functionality—tested and accepted by customers—within established schedule and cost criteria. However, our audit concluded that OIT instituted the PMAS concept without a roadmap identifying the tasks necessary to accomplish PMAS or adequate leadership and staff to effectively implement and manage the new methodology. Lacking such foundational elements, OIT has not instilled the discipline and accountability needed for effective management and oversight of IT development projects.

Specifically, OIT did not establish key management controls to ensure PMAS data reliability, verify project compliance, and track project costs. Also, OIT did not put in place detailed guidance on how such controls will be used within the framework of PMAS to manage and oversee IT projects. Consequently, the current PMAS framework does not provide a sound basis for future success. For example, the PMAS Dashboard's usefulness as a project management and performance monitoring tool is limited. The information maintained on the Dashboard is not always reliable and does not provide the project performance history needed to help senior VA leaders make informed project decisions. In addition, OIT has not established key management controls over items such as data reliability, PMAS compliance, and project costs—controls needed to make PMAS a viable IT oversight mechanism. Until these deficiencies are addressed, VA's portfolio of IT development projects will remain susceptible to cost overruns, schedule slippages, and poor performance.

To improve PMAS, VA must develop an implementation plan and assign adequate leadership and staff needed to fully execute the IT project management system. In addition, VA needs to establish controls for ensuring data reliability, verifying project compliance, and tracking costs to strengthen PMAS oversight. Finally, VA must prepare and provide users detailed guidance on using PMAS to ensure IT project success.

VA's Program Response
Estimated Resolution Timeframe: 2013
Responsible Agency Official: Assistant Secretary for Office of Information and Technology

Completed 2011 Milestones

During 2011, OIT with the Project Management Accountability System (PMAS) tracked the status of over 300 development and infrastructure projects and delivered over 80 percent of all scheduled product capability. Of these 300 development and infrastructure projects, 122 are Active – still in development, and 63 have been completed. The other projects are in various stages of further definition and planning. Delivering over 80 percent of all scheduled product capability represents more than 320 new products or product enhancements that had a positive impact on Veteran-facing functionality.

The PMAS system continues to be enhanced, with 6 product builds releasing new capabilities during 2011. Two of the primary software changes included the ability to track Baseline Date changes for projects and the ability to capture the number of Strikes that a project has received. The system tracks over 50 Universal Project Milestone (UPM) codes which describe the status of each project's Milestones. Two releases of the PMAS Guide, which sets policy, occurred in 2011, Vn. 2.1 and 3.0. The Red Flag and Strike processes were formalized, and meetings with OIT Executives are held on a weekly basis so that

projects can either escalate problems or report on why Milestones were not met on time. A Proof of Concept effort is underway to track project resource consumption and is expected to be rolled out during 2012. Migration of the PMAS systems to OIT's Austin Data Center and new production hardware providing expanded capacity and improved system performance and reliability were also accomplished in 2011.

Planned 2012 Milestones with estimated completion quarter

In 2012, OIT anticipates continuing the release of new PMAS capabilities. In addition, the PMAS Office, under the direction of the Deputy Assistant Secretary for Product Development, will stand up on October 1, 2011. This office will set policy and provide oversight and reporting on all Projects in development.

- New enhancements to the PMAS System will include the ability to interface with multiple VA financial and contracting systems to capture project obligations and expenditures. These enhancements are expected to be completed over the next two fiscal years **(2012 and 2013)**.
- A Prioritized List of the system interfaces to be developed will be established. **(Q1)**
- A new contract for the development of the System Interfaces will be required and is expected to be awarded by the end of **Q1**.
- Resource consumption will be tracked via a new project timekeeping system that is being implemented as part of the PMAS system. **(Q3)**
- A centralized repository for all project artifacts will be deployed and populated. **(Q3)**
- New PMAS requirements and system capabilities will be documented in the next release of the PMAS Guide. **(Q4)**
- Interim guidance will be provided to Project Managers as new features are released. Formal changes to the PMAS Guide will be documented at least once a year.

APPENDIX

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

HEALTH CARE DELIVERY

Audit of VA Consolidated Mail Outpatient Pharmacy Inventory Accountability, Report Number 08-02730-133, May 28, 2009

Audit of Consolidated Mail Outpatient Pharmacy Contract Management, Report Number 09-00026-143, June 10, 2009

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