SECTION III: OTHER INFORMATION

INSPECTOR GENERAL'S MANAGEMENT AND PERFORMANCE CHALLENGES

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

FOREWORD

The mission of the Office of Inspector General (OIG) is to serve veterans, their families and caregivers, and the public by conducting effective oversight of the Department of Veterans Affairs (VA) programs and operations through independent audits, inspections, investigations, and reviews. The OIG recommends advancements to VA services, processes, and systems that will improve the lives of veterans and make the best use of taxpayer dollars. The more than 864 OIG staff also work to deter and detect waste, fraud, and abuse. As part of these efforts, and in accordance with legal mandates, the Inspector General provides VA with this annual update summarizing the most serious management and performance challenges identified by OIG work, as well as an assessment of VA's progress in addressing those challenges.

The OIG recognizes that the Veterans Health Administration has the largest integrated public health system in the nation, and faces many of the same challenges as other healthcare systems—while trying to address the distinct needs of men and women who have served in the military. The decision-making functions and implementation of a wide-ranging benefits system is also a tremendously complex enterprise provided by the Veterans Benefits Administration. In addition, the National Cemetery Administration must ensure that the services and benefits it provides are delivered in a compassionate, dignified, and efficient manner. Each of these VA administrations requires strong, stable leadership and an effective web of support systems for financial management, procurement, information management, new technology, quality assurance, and other core services. It is hoped that in identifying deficiencies, making recommendations, and overseeing implementation plans, the OIG is helping VA to strengthen areas of weakness and to safeguard veterans' personal and financial well-being.

This report contains a summary of the major management challenges addressed by OIG's work and the status of VA's efforts to redress them. They are categorized within six areas of focus set out in the OIG's current strategic plan: (1) leadership and workforce investment, (2) healthcare delivery, (3) benefits delivery, (4) financial management, (5) procurement practices, and (6) information management.

The OIG will continue to work with VA to advance solutions that promote the best possible service and benefits to our nation's veterans and their families, and ensure strong stewardship of taxpayer funds.

MICHAEL J. MISSAL
Inspector General

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Major Management Challenge		Estimated Resolution Time frame (Fiscal Year)	Page #
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OIG CHALLENGE #1: LEADERSHIP AND WORKFORCE INVESTMENT

STRATEGIC OVERVIEW

VA is the second largest Federal employer and faces a number of challenges that are related to its size and complexity of operations. For FY 2018, VA is operating under a $188.7 billion budget, with over 379,000 employees serving an estimated 20 million Veterans. VA maintains a presence in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the U.S. Virgin Islands. It also operates the Nation's largest integrated health care system. Despite considerable resources, VA faces difficult challenges in carrying out its mission to serve Veterans, due in large part to major leadership and workforce investment shortcomings. The Office of Inspector General (OIG) has made VA leadership and governance issues a top priority in recognition that deficiencies in these areas ultimately affect the care and services provided to Veterans and allow significant problems to persist unresolved for years.

OIG SUB-CHALLENGE #1A: OVERCOMING A CULTURE OF COMPLACENCY

While VA employs many talented and committed people, one of the greatest obstacles to change is the sense of futility or culture of complacency among some staff and leaders. For example, *Critical Deficiencies at the Washington DC VA Medical Center* describes the breakdown of systems and leadership at multiple levels and an acceptance by many personnel that things will never change. This was evidenced by:

- Staff who got used to "making do";
- Normalization of noncompliant practices;
- Acceptance of information/data at face value without question; and
- Willingness to rationalize poor practices with "nobody's been harmed."[1]

The DC VA Medical Center has increased staffing in both Logistics and Prosthetics, which has resulted in improved operations in support of patient care. While staff that OIG recently interviewed generally reported being cautiously optimistic about culture change at the DC VA Medical Center, the lack of a permanent facility Director and Associate Director have slowed the facility's efforts at transformation.

Similarly, the OIG *Administrative Investigation of the VA Secretary and Delegation Travel to Europe* describes several derelictions by VA personnel

[1] Patient Safety was protected because many health care professionals and other staff at the DC VA Medical Center made significant efforts to ensure patients were safe and received quality care by using workarounds or trying to do the right thing.

concerning the former Secretary's trip and included findings related to poor judgement and misconduct by senior leaders. It is imperative that VA recognize the urgency in making strong leadership decisions now to oversee organizational changes needed to ensure proper accountability and governance.

VA'S PROGRAM RESPONSE: SUB-CHALLENGE #1A

VA understands human capital management is an integral component to providing world-class services to Veterans and their families. The Secretary is committed to creating a diverse, high-performing, and agile workforce that more readily serves the ever-changing needs of the Veteran by standardizing human capital policies, individual performance management, and human capital performance management systems. Essential to these efforts is ensuring the workforce is engaged, professionally developed, and held accountable for delivering excellent customer service and experiences.

VA acknowledges that sometimes staff members become accustomed to "making do" and accept normalization of noncompliant practices at certain sites facing significant leadership, resource, and infrastructure challenges. However, VA does not see this as depicting a "culture of complacency." In fact, VA staff at the Washington DC VA Medical Center (VAMC) actively went above and beyond to serve Veterans and to ensure no Veterans were harmed. What the Washington DC VAMC report depicts is the well-known phenomena of learned organizational helplessness. When employees repeatedly try to improve systems and processes and are unable to have an impact, the logical response is to eventually experience learned helplessness.

Fortunately, VA has an annual employee survey that measures aspects of organizational health, including learned helplessness. The question "Is it worthwhile in my workgroup to speak up because something will be done to address our concerns?" has been followed closely since 2014. While this measure dropped noticeably in 2016, it rose nicely in 2017 and again in 2018. This measure is being closely monitored and is being reported to senior leadership. Although improvement has been noted, there is still more work to be done to ensure staff feel empowered and proactive.

The best way for an organization to control learned organizational helplessness is to ensure employees are engaged. (OPM definition: Employees' sense of purpose that is evident in their display of dedication, persistence, and effort in their work and overall attachment to their organization and its mission). VA has taken multiple steps to address employee engagement (EE) in addition to the annual survey of organizational health. Besides making survey results available to all workgroups with at least five responses (15,817 workgroups in 2018), the VHA also provides an interactive dashboard that links priorities in action planning with tips for supervisors to engage in dialogue and garner best practices from high-performing facilities and workgroups. In addition, VA's National Center for Organization

Development offers customized assistance to the bottom 10 percent of sites. VHA has implemented VA Voices (a two-day program designed to improve EE and organizational climate) at 86 sites, with national implementation beginning in 2017, and has shown impressive results including improvement in Best Places to Work and organizational climate for VA Voices participants. VA has adopted servant leadership as its leadership framework and has instituted a serving leadership pilot program. VHA has established a national EE Committee as part of its VHA governance structure, which implemented the first ever VA Supervisors Week in June across VA, leveraging the extremely important role supervisors play in determining engagement. VA embraces the importance of EE and has established a VA wide Employee Engagement Council, in addition to naming EE champions at each site. The Veterans Benefit Administration, National Cemetery Administration, Office of Information and Technology (OI&T), and Board of Veterans' Appeals also have significant EE efforts underway.

VA is a leader in Customer Experience (CX) through its Veterans Experience Office (VEO).

VA is hardwiring CX as a core competency in the Department through the VEO to provide the best experiences in delivery of care, benefits, and memorial services to Veterans, Servicemembers, their families, caregivers, and survivors across the country.

CX enables VA to provide better services to Veterans by providing real-time Veteran feedback about their needs and experiences with VA.

Through VEO's CX framework, VA has operationalized how to apply CX capabilities to improve the Veteran experience. Core CX capabilities are real-time CX data and predictive analytics; tangible CX tools to empower employees to deliver outstanding experiences; modern, user-friendly technology; and targeted engagement

VEO has focused initial efforts on building a Patient Experience Program and will build a similar program for the Benefits Experience

VEO is a leader in CX capabilities and is sharing its model with other Federal agencies that are standing up or maturing CX capabilities

The Secretary of VA has issued a policy statement, championing VA's commitment to providing an excellent CX to all Veterans, Servicemembers, their families, caregivers, and survivors in our delivery of care, benefits, and memorial services.

VA has shown an urgency in making strong leadership decisions to ensure proper accountability and governance. VA established the Office of Accountability and Whistleblower Protection one year ago and both VHA and VA are well underway in redesigning their governance practices, processes, and structure. These changes will ensure that VHA will challenge the "sense of futility"/learned organizational helplessness and take advantage of its greatest strength – hundreds of thousands of talented employees dedicated to serving Veterans.

In reference to OIG Report No. 17-02644-130, *Critical Deficiencies at the Washington DC VAMC*, the facility has continued to address the overall culture of complacency through Town Hall sessions led by the Acting Medical Center Director, through e-mail communications from the Executive Leadership Team to the Washington DC VAMC staff, and through Executive Leadership engagement within the specific service lines to identify any challenges the staff face when conducting daily operational duties. The interviews for a new permanent Medical Center Director and Associate Director have been concluded and VA selected Mr. Michael S. Heimall to serve as the Medical Center Director. The Medical Center's Governance structure was formally established through the issuing of a policy memorandum and the structure of the governance communication was standardized to ensure transparency of decision making.

The Washington DC VAMC has engaged with several performance improvement experts within VHA to examine the processes within the facility and make significant improvements in the operations of the facility. Specifically, the Veterans Engineering Resource Center completed a highly successful project at the medical center. The aim of the project was to improve the patient flow in the Emergency Department and the project saw many major accomplishments; the highlight was an overall reduction in the percentage of Veterans boarding in the Emergency Department over 4 hours from 41.1 percent down to 13.3 percent in a 4-month time span.

Regarding the report on *Administrative Investigation of the VA Secretary and Delegation Travel to Europe,* the OM, Corporate Travel Office (CTO) conducted a detailed audit of the expense vouchers and travel authorizations for all travelers on the Europe trip. As part of that audit, CTO reconciled those records against travel policy and took appropriate action to correct all errors identified and process any overpayments, as required. The Office of General Counsel Ethics Specialty Team and CTO provided training on gift acceptance and travel planning and approval to over 250 employees on the Secretary's staff and senior staff and employees who have responsibilities related to their scheduling and travel in VA Central Office.

VA is committed to providing the best experiences in its delivery of care, benefits, and memorial services to Veterans, Servicemembers, their families, caregivers, and survivors through its employees and programs.

OIG SUB-CHALLENGE #1B: ADDRESSING KEY LEADERSHIP VACANCIES AND OTHER STAFFING SHORTAGES

The root cause for many issues identified during OIG oversight reviews was poor and unstable leadership and staffing shortages. At the current time, though VA has a recently confirmed Secretary, the Department has an Acting deputy secretary and Acting leaders for VHA and the Office of Information Technology. At the facility level, the same issues exist. For example, the OIG report, *Health Care Inspection: Evaluation of System-Wide Clinical,*

Supervisory, and Administrative Practices, Oklahoma City VA Health Care System describes how underlying causes for shortcomings within multiple program areas, processes, and operations were, in part, the result of leadership turnover and vacancies at multiple levels, most notably the Medical Director position, prior to May 2016. At the same time, this health care system experienced serious front-line staffing shortages.

During Comprehensive Health Care Inspection Program reviews for FYs 2017 and 2018, the OIG also found key leadership vacancies. For example, two of the four executive leadership positions at the Samuel S. Stratton VA Medical Center in Albany, New York, and the VA Southern Oregon Rehabilitation Center and Clinics in White City, Oregon, were filled by interim staff.

In four years of publishing the determination of VHA occupational shortages, the OIG has repeatedly noted the relatively long onboarding process and difficulty in finding suitable candidates. The most recent OIG analysis showed that 138 of 140 facilities listed the medical officer occupational series (or a related VHA assignment code) as experiencing a shortage, with the psychiatry and primary care positions being the most frequently reported. Of the 140 facilities reporting, 108 listed the nurse occupational series (or a related VHA assignment code) as experiencing a shortage, with practical nurse and staff nurse as the most frequently reported.

Staffing for future needs requires hiring in anticipation of future losses, as well as ongoing and projected changes in clinical demand, staffing productivity, and staff allocations. The OIG recognizes that VHA has made progress in implemented staffing models in specific areas such as primary care and inpatient nursing. VHA has also expanded the occupations covered by such models. However, operational staffing models that comprehensively cover critical occupations are still needed. Well-developed predictive staffing models would allow VHA to better assess and implement effective measures to address staffing shortage concerns.

VA'S PROGRAM RESPONSE: SUB-CHALLENGE #1B

In FY 2018, VHA formally authorized Workforce Management and Consulting (WMC) to stand-up the VHA Manpower Management Office (MMO). VHA has an aggressive schedule for establishing manpower capabilities, which includes (1) establishing staffing models for all functional areas; (2) benchmarking staffing, quality, and access at similar health care systems; (3) developing predictive recruitment models; and (4) identifying facilities in danger of critical staffing levels. VHA has many long-standing clinical staffing models (e.g., primary care, mental health, nursing, pharmacy) and is continuing to develop and validate others, especially for non-clinical functional areas.

The VHA Workforce Planning Cycle was redesigned to assist VHA identify potential shortage occupations and facilities at risk using a standardized, data-driven approach. VA looks to approve 1,200 new Education Debt Reduction Program (EDRP) awards in fiscal year FY 2018. Mission Critical Occupations including physicians,

registered nurses (RN), psychologists, pharmacists, physician assistants, and medical technologists received 90 percent of the new awards in FY 2018. With an average EDRP award of $75,000 per participant, VHA projects authorizing more than $90 million in FY 2018 new awards to retain critical providers for the next five years.

An enterprise-wide steering committee co-led by Workforce Management and Consulting and the Office of Human Resource Management completed a comprehensive review of all aspects of the VA Entrance and Exit Surveys. The workgroup submitted a list of 29 recommendations that moved forward for approval and once approved and implemented are expected to significantly improve the intended goals of the survey.

VHA conducted a detailed analysis of physician compensation by specialty by market to help target recruitment and retention resources to offset local labor market mismatches, which is estimated to be completed in September 2018.

Two separate training programs were implemented for Human Resource (HR) specialists: The 201 Jump Start and New Talent Development programs. The HR 201 Jump Start program is a virtual, self-paced orientation program for all new specialists to VA and/or the GS-201 occupation. The New Talent Development Program curriculum (virtual and face-to-face workshop) comprises 14 competencies applicable to all HR specialists, competencies in the specific functional areas of staffing, compensation, and employee and labor relations, all at the foundational level.

The first national trainee hiring event, the VA Mental Health Trainee and Early Career Recruitment and Connection Event, was launched in May 2018, with 85 participating VHA facilities and 1,700 interested candidates. VHA completed an in-depth analysis of regrettable losses for Mission Critical Occupations, completing four mitigation efforts and building sustainment plans for three multi-year efforts.

In reference to OIG Report No. 18-01693-196, *Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018*, VHA has made progress in standardizing workforce data across the system. The Office of Nursing Services (ONS), in collaboration with the Office of Nursing Informatics (ONI), Workforce Management and Consulting established changes to the RN assignment codes to improve the standardization and reliability of nursing workforce data. Approximately 12 percent of VHA RNs have had their assignment codes validated.

The VHA Manpower Management Office is anticipated to be established by September 30, 2018. VHA has taken several steps to establishing internal controls for position management including reducing the number of employees with this role in HR Smart from 2,000 to 4,000, developing interim position management policy and technical guidance, and completing two large-scale position management inventory reviews.

In reference to OIG Report No. 16-02676-13, *Health Care Inspection: Evaluation of*

System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma, OIG closed recommendations 1-6 , 8-17, 20, 22. The facility revised the committee structure to ensure robust data analysis and tracking. Cancelled appointments and audits of the Learning Organization staff are now reviewed by the facility and compared to invoices to determine if refunds are needed. Call center staff increased, weekly meetings address call center results, and the abandonment rate decreased by 40 percent. Test result notification is monitored by Office of Quality, Safety, and Value. An X-Ray unit and phlebotomy station in the Emergency Department are in place. The Facility Chief of Staff now reviews all diversion requests and Emergency Department status. The Environment of Care (EoC) committee now tracks completion of all deficiencies and conducts routine EoC rounds.

In reference to OIG Report No. 17-01740-62, *Comprehensive Health Care Inspection Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon,* only recommendation 2 remains open. The Anticoagulation Quality Assurance data are now reviewed by the Pharmacy and Therapeutics committee, with a goal of closure by October 2018. The delay is due to the change in reporting and tracking. Root Cause Analyses (RCA) are monitored by the Quality Leadership Committee to ensure eight RCAs are conducted yearly. Routine EoC rounds attendance is documented and reported to the EoC Committee. Attendance of appropriate staff at the community Nursing Home Oversight Committee is routinely monitored and reported to Medical Executive (MEC). Cyclical clinical visits to Community Nursing Homes by social workers and RNs have been monitored and VHA standard has been achieved. Weekly contraband inspection of Mental Health Residential Rehabilitation Treatment Program patients is performed and documented to VHA standards. Closed circuit cameras are on line and are monitored to VHA standards. Signs warning of Closed Circuit Television monitoring are in place.

In reference to OIG Report No. 17-05407-141, *Comprehensive Health Care Inspection Program – Review of the Samuel S. Stratton VA Medical Center, Albany, New York*, recommendations 1 - 10 are open. The facility MEC implemented review of Ongoing Professional Practice Evaluation monthly. Physician Utilization Management Advisors are now in place for all services, and compliance is reported to the Office of Quality, Safety, and Value (QSV) Committee monthly. The Chief of Business Operations now reviews the Utilization Management data with the QSV Committee. RCA findings are reported to the Nursing Quality Assurance Council and the MEC. Completion of recommendations is documented in committee minutes. The EoC policy was revised and inspections are conducted to VHA standards. Compliance is monitored in the EoC Committee, including required attendance by members. Locks on biohazardous waste rooms were replaced with keypad locks. Controlled Substances Inspectors randomly audit

orders, and orders are double-checked by the Controlled Substances Coordinator. Results are reported to the QSV Committee. Prescription pad inventory is monitored by the Controlled Substances Inspectors and then checked by the Controlled Substances Coordinator, with review by the QSV Committee. A monitoring system for communication of mammogram results to patients was also implemented.

In reference to OIG Report No. 16-03405-80, *Health Care Inspection – Primary Care Provider's Clinical Practice Deficiencies and Security Concerns, Fort Benning VA Clinic, Fort Benning, Georgia*, recommendations 5 and 8 remain open. The patient's care was assessed. A comprehensive process to inform patients of test results was implemented and is monitored monthly by the Quality Management department. Health Information Management hired additional staff to randomly monitor use of cut and paste and adherence to VHA documentation standards. The facility instituted the One Consult model for consultation tracking. Consults are tracked by the Executive Leadership Team daily. The facility has completed mandatory Prevention of Disruptive Behavior Training for employees, as well as Emergency Management employee training. The Emergency Codes and Response guide was revised and communicated to all employees.

OIG SUB-CHALLENGE #1C: INVESTING IN WORKFORCE DEVELOPMENT

To meet VA's important mission, VHA has committed to reducing their regrettable losses and implementing staffing models for critical need occupations. VA leaders must cultivate their workforce by providing regular and constructive performance feedback and intervening promptly to address issues of concern. However, recent reviews identified serious problems regarding the medical care delivered by certain VA providers that must be rectified quickly by VHA leaders. Further, recent OIG reviews highlighted concerns regarding training and performance management for VBA staff. For example, *Audit of VBA's National Pension Call Center* describes how VBA did not have reasonable assurance that the call center's staff were properly trained to provide timely and quality assistance to Veterans and their families. Also, VBA supervisors were not required to take corrective actions when inaccuracies in information provided to callers were identified.

VA'S PROGRAM RESPONSE: SUB-CHALLENGE #1C

On December 26, 2017, VBA issued the FY 2018 Benefits Assistance Service (BAS) National Training Curriculum, which includes training requirements for the National Pension Call Center (NPCC). The analysis and reporting requirements are in place and VBA issued the initial compliance report to the Philadelphia Regional Office (RO) for action on February 26, 2018. This is the standard analysis tool that VBA utilizes to ensure compliance with monthly training requirements.

VBA's NPCC personnel have completed their required training. VBA developed a SharePoint tracking site that was deployed in November 2017 to manage the process

of identifying deficiencies to track and monitor all required follow-up and corrective activities. VBA has implemented a process for logging, tracking, and recording appropriate resolutions for all corrective actions. Quality scores for the NPCC were 91 percent for the month of September 2018 and 90 percent cumulative for FY 2018. Both scores exceeded the dashboard performance target of 89 percent.

To better serve Spanish-speaking Veterans, VBA's BAS Quality Client Services team has a bilingual employee who began reviewing a sample of randomly-selected Spanish-speaking calls for coaching and feedback purposes on October 1, 2018. However, quality evaluations for National Quality purposes will not occur until an additional bilingual VBA employee has been hired, as a multi-level review and validation process is required for National Quality reviews.

VHA is committed to investing in workforce development to include reducing regrettable losses where possible, implementing staffing models for critical occupations, providing regular and constructive performance feedback, and intervening promptly to address issues of concern.

In FY 2018, VHA has formally authorized WMC to stand-up the VHA MMO. VHA has an aggressive schedule for establishing manpower capabilities, which includes (1) establishing staffing models for all functional areas; (2) benchmarking staffing, quality, and access at similar health care systems; (3) developing predictive recruitment models; and (4) identifying facilities in danger of critical staffing levels. VHA has many long-standing clinical staffing models (e.g., primary care, mental health, nursing, pharmacy) and is continuing to develop and validate others, especially for non-clinical functional areas. The VHA MMO office is anticipated to be established by September 30, 2018. VHA also completed an in-depth analysis of regrettable losses for Mission Critical Occupations, completing four mitigation efforts and building sustainment plans for three multi-year efforts.

In terms of providing regular and constructive performance feedback, VHA has led the way on implementing an automated performance management system. VHA has contracted with Northrop Grumman since 2011 to pilot and expand ePerformance capabilities, resulting in a solution configured to handle the many intricacies of VA's performance appraisal process from bargaining unit 0750 forms to Senior Executive Service performance and everything in between. ePerformance is transforming VA's current performance management culture through system-driven compliance, increased transparency, aligning performance planning priorities to agency goals, and driving accountability and results. This is accomplished through automation of the entire performance management process including plan creation, mid-cycle review, final rating, and transfer to the electronic Official Personnel File (eOPF). ePerformance is the only application of its kind that interfaces with Office of Personnel Management's eOPF system, allowing for the automated upload of performance appraisal documents to the eOPF. ePerformance is being deployed

incrementally across the VA system, with approximately 12,000 users currently within medical centers, staff offices, and OIT. We anticipate expanding the user base to 75,000 next year and to include NCA, Board of Veterans Appeals, and Readjustment Counseling Service, as well as additional medical centers in VISN 8.

In reference to OIG Report No. 18-01693-196, *Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018*, VHA has made progress in standardizing workforce data across the system. WMC, in collaboration with the ONS and the ONI, established changes to the RN assignment codes to improve the standardization and reliability of nursing workforce data. Approximately 12 percent of VHA RNs have had their assignment codes validated. A second workgroup co-led by the Office of Specialty Care and WMC are finalizing a proposed list of physician assignment codes to be implemented in FY 2019.

The VHA MMO office was authorized in July 2018. Key MMO program functions and activities have commenced with detailed staff. Recruitment for permanent staff is anticipated to occur in January 2019 after resources have been identified during a manpower review of VHA Central Office. VHA has taken several steps to establishing internal controls for position management including reducing the number of employees with this role in HR Smart from 2,000 to 4,000, developing interim position management policy and technical guidance, and completing two large-scale position management inventory reviews.

VA leadership development programs are oriented toward preparing capable, motivated, and engaged servant leaders. An integral part of engagement is setting clear performance expectations, providing frequent feedback, and jointly addressing areas of concern with staff. Each of the VA leadership development programs – from Aspiring Leaders to New Supervisors to Senior Executive Service Candidates – now have sessions dedicated to managing performance and conducting related crucial conversations. The ability of VA leaders to apply these leadership skills continually improves with advances in operational and performance management tracking systems and ongoing efforts to create a culture of engagement.

KEY RELATED LINKS:

- OIG Report, Critical Deficiencies at the Washington DC VAMC, Report No. 17-02644-130, March 7, 2018.
- OIG Testimony, "The Curious Case of the VISN Takeover: Assessing VA's Governance Structure," May 22, 2018.
- OIG Report, Administrative Investigation – VA Secretary and Delegation Travel to Europe, Report No. 17-05909-106, February 14, 2018.
- Inventory of OIG Comprehensive Health Care Inspection Program Reports, 2017 to present.
- OIG Report, Health Care Inspection: Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, Oklahoma City,

Oklahoma, Report No. 16-02676-13, November 2, 2017.
- OIG Report, OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018, Report No. 18-01693-196, June 14, 2018.
- OIG Report, Comprehensive Health Care Inspection Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon, Report No. 17-01740-62, January 11, 2018.
- OIG Report, Comprehensive Health Care Inspection Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York, Report No. 17-05407-141, March 29, 2018.
- Inventory of OIG Determinations of VHA Occupational Staffing Shortages, FY 2014 to present.
- OIG Report, Health Care Inspection – Primary Care Provider's Clinical Practice Deficiencies and Security Concerns, Fort Benning VA Clinic, Fort Benning, Georgia, Report No. 16-03405-80, January 30, 2018.
- OIG Report, Audit of VBA's National Pension Call Center, Report No. 16-03922-392, November 1, 2017.

OIG CHALLENGE #2: HEALTH CARE DELIVERY

STRATEGIC OVERVIEW

In 2018, VHA anticipates that it will provide health care services to over 7 million patients through its network of more than 140 hospitals and 1,200 outpatient sites as well as through care purchased from non-VA providers in the community. VHA continues to face significant obstacles in delivering timely and quality health care to Veterans. A number of the OIG's FY 2018 audit and health care inspection reports highlight some of the key concerns that follow.

OIG SUB-CHALLENGE #2A: IMPROVING QUALITY OF CARE

VHA experiences many challenges as it seeks to provide quality medical care to Veterans. Rural and underserved populations, the difficulty in providing specialty care to women, and the efficient operation of the business aspects of medical care delivery, are among the many challenges to VA. VHA's efforts to provide quality health care are complicated by such nationwide challenges as those experienced with addressing opioid abuse, including the difficulties associated with providing and coordinating care with non-VA providers. The OIG has expressed particular concern for high-risk patients with chronic pain and mental illness.

Opioid abuse has become a serious public health emergency, with Veterans particularly hard hit. It is not surprising that given the prevalence and complexity of chronic pain in the Veteran population, overdose deaths occur at much higher rates than in the civilian population.

With increasing opioid overdose deaths, the VA's emphasis through its Opioid Safety Initiative (OSI) and other recent efforts has

appropriately shifted to opioid dose reduction, when appropriate; increased assessments; and closer monitoring of patients on chronic opioid therapy. The OIG recognizes that even with this progress, much more still needs to be done to build on these efforts. Patients suffering from chronic pain and mental illness who receive opioid prescriptions from non-VA providers—providers whose opioid prescribing and monitoring guidelines can conflict with VA guidelines—may be especially at risk. The risk is exacerbated when information about opioid prescriptions is not routinely shared between VA and non-VA providers. Because of identified challenges related to health information sharing between VA and community providers, the OIG also has noted that non-VA providers do not consistently have access to critical health care records regarding Veterans they are treating.

VA'S PROGRAM RESPONSE: SUB-CHALLENGE #2A

The VA's OSI emphasizes reduced reliance on opioid medication for pain management, while instituting and expanding non-pharmacological evidence-based pain therapies that allow for Veteran-centric multimodal pain care. For patients requiring opioid medication for pain, the goal is to allow for optimization of dosage (with reduction if clinically indicated) and risk mitigation strategies systemwide. VA continues to identify new opportunities in providing safe and responsible care to each Veteran. As of FY 2018 Q3 (and since FY 2012 Q4):

- VA pharmacies dispensed prescriptions with a Morphine Equivalent Daily Dose greater than or equal to 100 to 66 percent fewer Veterans.
- VA providers increased data-based patient case risk reviews of high-risk opioid therapy patients.
- 53 percent more Veterans on long-term opioid therapy have a documented urine drug screen completed in the last year.

In keeping with the VA's commitment to be the most transparent agency in Government, since FY 2018 Q1, VA began posting information publicly on opioids dispensed from VA pharmacies, along with VA's strategies to prescribe these pain medications appropriately and safely. This information can be found at https://www.data.va.gov/story/department-veterans-affairs-opioid-prescribing-data.

The VA is committed to enhancing the safe and efficacious care of Veterans who are exposed to opioid drugs. Deploying risk mitigation strategies or modifying treatment plans for patients at elevated risk of experiencing an adverse event related to an opioid prescription or opioid use disorder diagnosis can reduce the likelihood of these events and improve patient outcomes. Released in March 2018, VHA Notice 2018-08 establishes policy on implementation of OSI case reviews and Title IX, Subtitle A, Section 911(a)(2) of the Comprehensive Addiction and Recovery Act. These case reviews must be documented in the medical record using a note title or titles that include the terms "Opioid Risk Review" and "Data-based." These both require completion and documentation of case reviews of opioid-related risks, specifically for the following two groups of patients:

(a) Patients identified as being in the "Very High – Opioid Prescription" risk category for an overdose or suicide-related event by the Stratification Tool for Opioid Risk Mitigation; these patients must be included in the interdisciplinary OSI case reviews of patients with high-risk opioid prescribing at each facility

(b) Patients with new opioid prescribing, before initiating opioid therapy by the health care provider.

OIG has stated that "patients suffering from chronic pain and mental illness who receive opioid prescriptions from non-VA providers—providers whose opioid prescribing and monitoring guidelines can conflict with VA guidelines—may be especially at risk."

To mitigate this risk, VA has extended the following opioid-related efforts to community providers caring for Veterans:

- VA requires opioid prescriptions for non-urgent or non-emergent therapy lasting longer than a couple of weeks to be provided by VA providers to ensure proper monitoring.
- VA is updating the OSI dashboard to provide statistics on community providers to deliver the same monitoring as for VA providers.
- VA requires the same opioid safety training for community providers as VA providers.
- Though there is no mechanism (or capacity) for VA oversight where community providers are concerned, they (like VA providers) are required to query state prescription drug monitoring program (PDMP) databases (pursuant to the laws of the state the provider is practicing in).
- Community providers will also be included in academic detailing, as are VA providers.

The OIG noted that risks of patient harm and adverse events are exacerbated when information about opioid prescriptions is not routinely shared between VA and non-VA providers. Because of identified challenges related to health information sharing between VA and community providers, the OIG also has noted that non-VA providers do not consistently have access to critical health care records regarding Veterans they are treating. The VA will continue to implement new medical documentation tools and processes that simplify the sharing of applicable medical history information including medication lists with community providers.

To ensure a comprehensive program exists, VA clinicians require access to a Veteran's opioid therapy history from outside providers, thereby ensuring safe pain management care is provided. Most states are required to provide a Veteran's opioid medication history via PDMP, which providers must query according to applicable laws/requirements. VHA Directive 1306 Querying State PDMPs describes the purpose, policies, and responsibilities related to PDMP checks for VA providers. State participation and state data sharing with the VA varies widely:

- As of April 2018, 48 states, Puerto Rico, and the District of Columbia are fully activated for PDMP data transmission.
  - Missouri does not currently have a statewide program that is operable.

  - Nebraska has completed updating their system to achieve the Federal requirement for use of fair information practices 140-2 cryptographic encryption, and VA is in the process of establishing connectivity.
- PDMP checks are performed individually by VA staff using the differing state interfaces, manually recorded in the patient's electronic record, and as of April 2018, 73.91 percent of current Long-Term Opioid Therapy Veterans had a PDMP check documented within the last 365 days.
- From FY 2013 Q3, ending in June 2013 to FY 2017 Q4, VA providers have documented over 2.3 million queries to State PDMPs to help guide treatment decisions.
- VA providers currently have access to the following PDMP-related data via the Opioid Therapy Risk Report:
  - Date and time of last PDMP inquiry
  - Number of days since last PDMP check
  - VA location where last PDMP was entered
  - PDMP entered by staff
  - PDMP signed by staff
  - PDMP source clinic.

To further improve the timeliness of available data and allow providers real-time clinical decision support, a multi-disciplinary, enterprise-wide VA group is working on formal requests of the VA Enterprise to build an electronic interface between VA's current and future EHR and the PDMPs.

VA is also working with Congress, OI&T, and Cerner via interdisciplinary, cross-enterprise workgroups to incorporate opioid safety informatics into VA's modernized EHR, improve the ease with which VA can query PDMPs, and share and receive health information from the community.

In reference to OIG Report No. 17-02644-130, *Critical Deficiencies at the Washington DC VAMC*, the Washington DC VAMC has actively engaged with the VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (RAPID) to aggressively improve the overall quality of care being delivered to the Veterans served. In working with this team, the Washington DC VAMC has dramatically reduced the overall rate of blood stream infections associated with central lines from 5.76 per 1,000 central line days down to zero and reduced the total number of hospital acquired C-Diff cases from a rate of 10.64 infections per 10,000 bed days of care to 4.36 infections per 10,000 bed days of care. The RAPID team has been on-site at the Washington DC VAMC on three separate occasions and has engaged dozens of staff and facility leaders who are actively working on multiple initiatives throughout the medical center to improve the overall quality of care.

In reference to OIG Report No. 13-01743-192, *Combined Assessment Program Summary Report: Evaluation of Moderate Sedation in Veterans Health Administration Facilities*, this report was published in May 2013. The report is closed and no actions were taken in FY 2018.

In reference to OIG Report No. 16-01091-06, *Health Care Inspection – Opioid Agonist*

Treatment Program Concerns, VA Maryland Health Care System, Baltimore, Maryland, this report is closed. The facility revised the cited policies and ensured that the director of the program is physically present full-time. Policies are consistent with Title 42 of the CFR Part 8 and Substance Abuse and Mental Health Services Administration guidelines. A cardiac risk assessment standard operating procedure is in place. Counseling sessions are audited and comply with the standard.

OIG SUB-CHALLENGE #2B: ENHANCING ACCESS TO CARE

As in prior years, access to health care continues to be a significant challenge for VHA. For more than a decade, the OIG, Government Accountability Office, VA, and other organizations have issued numerous reports regarding concerns with delays or barriers for accessing VA care. These include lengthy or inaccurately recorded Veteran wait times, poor scheduling practices, consult management backlogs, and Choice program concerns with care in the community. VA has made efforts to provide same-day services for Veterans needing immediate mental health or primary care. Also, VA is in the process of consolidating their community health care programs into a single program that meets the needs of Veterans, community providers, and VA staff. However, in FY 2018, OIG reviews at VISN 15 and at a number of other VA medical facilities demonstrated that VHA continues to experience significant problems with access to care delays that can affect Veterans' health. For example, OIG's review of VISN 15 disclosed the following deficiencies:

1. Medical facilities did not record accurate wait times for an estimated 38 percent of new mental health or specialty care appointments.
2. Veterans who received care through the Choice program waited more than 30 days (which is the standard) from the clinically indicated date for their appointment an estimated 41 percent of the time.
3. VISN 15 did not consistently manage specialty care consults in accordance with policy.

VA'S PROGRAM RESPONSE: SUB-CHALLENGE #2B

As a part of the VA's highest access priority to meet the urgent health care needs of Veterans, VA implemented same-day services for care needed right away in primary care and mental health at the more than 1,000 clinic locations. Additionally, over the past year, VA added same-day services in prosthetist and orthotist clinics at its medical centers and is currently working to add same-day services for substance use disorder services at all medical centers. Focusing additionally on meeting the urgent needs of Veterans, VA further reduced the time to complete stat referrals to a specialist from 3.1 days in FY 2017 and down to 2.0 days in FY 2018 through mid-July; this number continues to decrease, most recently down to 1.3 days during the month of June. VA also has been focusing on the timeliness of time-sensitive follow-up appointments. For FY 2018 through July 25, 95.3 percent of the approximately 252,000 completed time-sensitive appointments occurred no later than the provider-recommended date

(improved from 90 percent a year ago). In FY 2017, 22 percent of face-to-face appointments were completed the same day they were requested.

VA has been working to resolve inaccuracies in Veteran appointment wait times due to scheduling errors. To improve knowledge about accurate scheduling processes, VA has been requiring that all staff that schedule appointments complete face-to-face scheduler training, including hands-on scheduling exercises with supervisory feedback and the requirement to pass a final examination. Schedulers may not schedule appointments until they successfully complete this training. To date, over 40,000 staff have completed this program. Also, over the past year, VA implemented an enhanced scheduler auditing system, ensuring that 100 percent of scheduling staff undergo auditing of a sampling of the appointments they schedule. Such audits enable direct feedback to individual schedulers and aggregated audit results provide target areas for future educational focus. During the last six-month cycle (October 1, 2017 – March 31, 2018), 100 percent of the required audits were completed across VA (about 806,000 scheduling audits); VA is on track to be at 100 percent during the current six-month cycle ending September 30, 2018. The Office of Veterans Access to Care (OVAC) has also been working with the Office Compliance & Business Integrity to ensure the timeliness and accuracy of consults and with the Office of internal Audit and Risk Assessment to ensure the accuracy of scheduling and scheduler audits.

VA has also been implementing two scheduling system software fixes to assist with reducing scheduling errors; one fix ensures that the provider-recommended date for the appointment referrals to a specialist (consults) automatically gets transferred into the scheduling system. The second fix automatically transfers the provider-recommended date for a follow-up appointment into the scheduling system. Since December 2017, there have been over 13.5 million returns to clinic orders entered in Computerized Patient Record System (CPRS) that transferred to Veterans Scheduling Enhancement (VSE), with 96.6 percent of orders being closed by schedulers using VSE. VSE is the first major software update to VA's scheduling system in over two decades. The software fixes eliminate the possibility of schedulers altering the automatically transferred date when making an appointment and thereby prevent these frequent prior causes of scheduling errors identified by OIG. Since VA began to publicly report new patient appointment wait times from the date an appointment is requested (create date) at www.accesstocare.va.gov in April 2017, there have been over 400,000 website users. This "date an appointment is requested" method includes data that cannot be altered by schedulers. VA believes these system changes will improve the accuracy of wait time reporting including identification of patients eligible for care in the community. This website also transparently publishes patient satisfaction, same-day service options, and quality data for Veterans, their families, and the public and provides helpful information for every VA medical center and clinic to assist

Veterans as they make decisions about where and when to receive care. This degree of transparency does not exist in private sector health care systems.

From FY 2016 to FY 2017, the national VA average wait times for completed new patients from the date of the appointment request (create date) improved from 22.1 days to 21.8 days in Primary Care and from 12.0 to 11.2 days in Mental Health. Both specialties are on track to have even shorter wait times for FY 2018. Based upon available published studies, the average wait times for new appointments are shorter in VA than outside the VA in primary care, cardiology, dermatology, gynecology, and mental health.

Over the past year, VA has been focusing on reducing missed appointments because of Veteran no-shows. A major part of this effort has been a communications campaign to Veterans to encourage them to let us know if they cannot make their appointment. Another major part of this endeavor has been the national rollout of a nationwide text messaging appointment-reminder system that includes the ability for the Veteran to automatically cancel their appointment if they respond to the text that they cannot keep their appointment. To date, about 21 million texts have been sent to 3.5 million Veterans and this has resulted in 375,000 cancelled appointments. Thus far, the campaign and texts have helped VA reduce no-shows by over 100,000 appointments. The no-shows are expected to continue to decrease as VA focuses on efforts including the ongoing Veteran communications campaign ensuring that VA has the latest cell phone number that the Veteran uses.

VA continued to grow the number of clinics types where Veterans may directly schedule an appointment in a clinic without first requiring a referral from a primary care provider. While this previously had been achieved in Audiology and Optometry Clinics, over the past year, Nutrition and Food Service, Wheelchair and Mobility, Amputation Care, and Podiatry clinics were all added and now have such scheduling capability for all their clinics across the country. VA is in the process of adding additional specialties including Weight Loss, Social Work, and Clinical Pharmacy.

Progress has also been made with VA's Access "True North" by having patient satisfaction for wait times independently be measured using surveys through the Consumer Assessment of Health Providers and System. Results of average satisfaction scores are demonstrated in the table below. Over the past 2 years, the scores have improved in all four domains.

SECTION III: OTHER INFORMATION

	FY 2016	FY 2017	FY 2018 through April
Primary Care Routine Care	83.6%	84.5% (+0.9% from FY 2016)	85.6% (+1.1% from FY 2017)
Primary Care Needed Right Away	72.4%	74.2% (+1.8% from FY 2016)	75.2% (+1.0% from FY 2017)
Specialty Care Routine Care	82.2%	83.5% (+1.3% from FY 2016)	85.2% (+1.7% from FY 2017)
Specialty Care Needed Right Away	72.4%	74.1% (+1.7% from FY 2016)	75.8% (+1.7% from FY 2017)

VA established and implemented standard monitoring procedures and controls to ensure all Veterans Choice Program (VCP) contract performance standards and requirements, including those standards for medical appointment timeliness, are met. The VCP Quality Assurance Surveillance Plan (QASP), pursuant to the requirements listed in the VCP contract's performance work statement, sets forth the procedures and guidelines VHA uses to ensure the required performance standards and service levels are achieved by the VCP Third Party Administrators (TPA).

VA has worked aggressively since the start of the VCP contract to address specific issues affected by untimely appointment scheduling and medical documentation returns. VA's implemented procedures also included controls to ensure that VCP performance-related data is reported by the TPAs in a timely and consistent manner and is analyzed monthly by both TPA and VHA staff. The VCP QASP oversight processes have helped improve TPA performance over the life of the contract and have led to positive improvements in medical appointment timeliness.

Related to the VISN 15 report, TriWest's overall performance since January 2018 has exceeded the minimum performance standard for both routine care appointment timeliness measures. In fact, the performance standards have been met or exceeded since the end of FY 2017.

VHA has also noted an overall positive trend in TriWest's performance for the return of outpatient medical documentation. TriWest met the performance standard of 90 percent in February 2018 (achieving a 92 percent overall performance rate year-to-date) and has continued improving since then. TriWest has not yet met the performance standard of 95 percent for inpatient medical documentation returns. In May 2018, VHA issued a letter of correction to TriWest regarding this matter. TriWest responded with an appropriate action plan that includes a post-appointment outreach program and obtaining better access to hospital electronic medical records through increased use of CIOX, which is the company TriWest uses to facilitate the transfer of medical documentation.

VA considers that appropriate controls and monitoring activities have been

implemented to oversee appointment and medical documentation timeliness in accordance with the VCP contracts. VA has also implemented an automated process to accurately capture the wait time for appointment by implementing a process that automates the Patient Indicated Date (PID), also known as the Clinically Indicated Date, to ensure the clinician documented return to clinic date is automatically downloaded into VHA's scheduling system as the PID.

VHA will continue to monitor TriWest and future TPA performance and improvement to ensure that all contract performance standards are met and adhered to.

Looking towards the future, the VHA OCC began working collaboratively with OVAC, the VA OI&T and other VA central office program offices to align processes and to further evaluate modifications to the current wait time goals and process enhancements to establish achievable wait time goals for the consolidated community care program that can be monitored and then compared to wait times at VHA medical facilities.

The MISSION Act passed in 2018 consolidates the Community Care Program. VHA was given one year from the signing of the law to establish new access standards, implement them, and develop a process to evaluate whether the standards and goals are achievable. VHA is currently following protocol and obtaining wait time standard recommendations from the Centers for Medicare and Medicaid Services (CMS), DoD, and the public to inform VHA's final decisions regarding achievable wait time standards for Veterans receiving care inside VA or in the community.

Additionally, OCC, in collaboration with OVAC, OIT, other program offices, and contracting partners have agreed on an interim solution to measure the wait times for Veterans receiving care in the community when the requested service initially went to a clinic within the VAMC and was forwarded to the facility's community care office. This new report will be available for evaluation and distribution by the end of FY 2018. The interim solution will be in place until the consolidated program is fully implemented and the new information technology systems that are being developed to fully adhere to this recommendation are deployed nationally.

In reference to OIG Report No. 15-03364-380, *Audit of VHA's Management of Primary Care Panels*, to improve oversight of facility-set panel sizes, VHA's Office of Primary Care (OPC) directed each VISN and their respective VA medical facilities to verify that they have reviewed and incorporated necessary changes to facility-set panel sizes based on the guidance outlined in VHA Directive 1406. Additionally, OPC directed each VISN to perform a review of all panel overrides that are not consistent with VHA-recommended modeled capacities and review the justification. OPC sent quarterly requests for validation of Patient Centered Management Module (PCMM) data to VISN point of contacts in FY 2017. VISNs documented their review of PCMM Web data, which included staffing, examination rooms, panel capacities, and justifications and returned their reviews to OPC. OPC conducted the first of two bi-annual reviews of VISN findings in FY 2018 Q1. The

review resulted in recommendations from OPC to VISN PC points of contact (POC) that warranted further review or action by facilities. OPC is following up with VISN PC POC to ensure justifications for overrides are documented accurately and appropriately. The second biannual review will be conducted in FY 2018 Q4.

In June 2018, a Provider Utilization Initiative was initiated that requires primary care providers who are more than 0.2 full time equivalent (FTE) and less than 80 percent of their modeled panel size to provide virtual primary care to sites experiencing provider shortages. This initiative matches supply with demand, aligning with our additional responsibility to be a good steward of resources. Implementation for facilities took place on August 6, 2018. The OIG report remains open pending results of OPC's second biannual audit of VISN findings.

In reference to OIG Report No. 17-00481-117, *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15*, VISN 15 requested closure on recommendations 1, 3, 4, 5, 8, 9, and 10. VISN 15 implemented use of the National Scheduling Training curriculum, mandatory scheduling audits, and reviews of audits in a monthly meeting; in addition, individual scheduling audits and mandatory remedial training are in place. The Colorectal Cancer Screening Reminder System. The One Consult Model was implemented to manage and track internal and community care consults with a 100 percent tracking rate. VISN 15 implemented a standard operating practice (SOP) for communicating specific audit results from facilities to VISN 15 and submitted meeting minutes and audit results. Each facility has attested to the development of a local SOP for care consults and a local SOP to deactivate a consult service when the service becomes unavailable.

In reference to OIG Report No. 17-00414-376, *Review of Alleged Use of Inappropriate Wait Lists for Group Therapy and Post Traumatic Stress Disorder Clinic Team, Eastern Colorado Health Care System (ECHS)*, this report is closed. ECHS has achieved actions on consults within seven days of the consult entry date. Additional staff have been hired for Colorado Springs to oversee scheduling and clinic administration. ECHS complies with the scheduling guidelines for mental health groups using Electronic Wait Lists.

OIG SUB-CHALLENGE #2C: ENSURING THAT EFFECTIVE CORE SERVICES ARE AVAILABLE TO PROMOTE QUALITY AND TIMELINESS OF CARE

In the promotion of quality and timeliness of VHA care, the OIG has observed specific progress in quality improvement and patient care processes during Comprehensive Health Care Inspection Program reviews. For example, in the areas of Quality, Safety, and Value, the OIG found that facility managers implemented improvement actions recommended by Peer Review Committees. The OIG also observed notable improvement in the performance of medical history evaluations and physical examinations and pre-sedation assessments to establish baseline status and procedural appropriateness prior

to the performance of invasive procedures requiring moderate sedation.

However, hospital conditions pose an intrinsic risk to patients as personnel contend with unpredictable situations, infection control, large numbers of vulnerable individuals with significant care needs, and changing demands on a daily basis. Given these challenges, it is critical that hospitals have effective core services, including supply and equipment inventory controls that promote quality patient care and safety. Recent oversight reviews, the most noteworthy of which was at the Washington DC VA Medical Center, illustrate the resourcefulness and dedication necessary for medical professionals to provide quality care when a hospital's essential business functions are broken.

The breakdown of core services present risks to patients, particularly when the lack of supplies or instruments causes surgical procedures to be canceled or delayed. During the 2017 DC VA Medical Center site visits and OIG's interviews with VA Central Office staff, a common theme was that Logistics was not always viewed as a critical player in patient care operations. The DC VA Medical Center report has shifted that mind-set such that facility staff reported having a clearer sense of Logistics' contributions and value to quality patient care that the OIG hopes will be adopted in other facilities as well.

VA'S PROGRAM RESPONSE: SUB-CHALLENGE #2C

The goal of the VHA Supply Chain Program Office (SCPO) is to ensure an effective supply chain quality management system to direct organizational activities toward meeting Veteran requirements and continuously improving effectiveness and efficiency. Focused quality assurance, quality control, and field-based performance management support are paramount to ensuring effective core services are available to promote quality and timely care. Within the VHA SCPO, a robust, process-oriented quality assurance and quality control program is paramount to meeting patient expectations and initiating changes that improve patient comfort, clinical outcomes, and patient satisfaction levels.

Through the recurring, established quality review activities, the SCPO focuses on systematic performance measurement and process monitoring, with an established feedback loop for error reduction. With a focus on process improvement, waste reduction, and facilitating and identifying training opportunities, the extant quality management program is significant to the assessment, correction, and monitoring of important aspects of patient care. By the end of FY 2018, the SCPO will have overseen over 18 VISN Quality Control Reviews (QCRs) of their VAMCs, and closely monitored the completion of more than 120 additional VAMC QCRs by their VISNs. The SCPO has also provided, or coordinated over 20 individual assist visits to improve supply chain support, and has established an innovation program to develop and promulgate best practices to reduce process variation and improve efficiency.

By promoting a well-defined health care supply chain quality management program, a system exists for rapid identification of improvement opportunities in areas that can impact patient care or safety and make immediate changes. The strength of the quality management program is that it not only assists with improving clinical outcomes, but it also promotes staff engagement by encouraging facility staff at every level of the organization to provide feedback and help improve performance throughout the medical facility. We advance a program that meets Veterans health care requirements to instill confidence in the Administration. Full resolution will be at the completion of VA's comprehensive Supply Chain Transformation at the end of 2024.

In response to OIG Report No. 16-03743-193, VHA has successfully worked towards closure of all recommendations except for one. The one response that remains open is the recommendation to ensure senior and clinical managers evaluate licensed independent practitioners' ongoing professional performance regularly according to the frequency required by facility policy. VHA has worked towards creating a strong intervention through the development of a standardized auditing tool. As additional risk has been identified through other reviews and work, this auditing tool has been expanded to address those concerns. The product and tool are being finalized and tested with anticipated completion in Q1 FY 2019. The other four recommendations were closed in 2018 with the submission of updated tools, processes and audits to show continued assessment and response to risks identified in the 2016 report.

In reference to OIG Report No. 17-02644-130, *Critical Deficiencies at the Washington DC VAMC*, the Washington DC VAMC has overcome many challenges since the release of the Critical Deficiencies Report and the identification of the core services that are essential to supporting the overall Veteran health care delivery is paramount to our continued mission. Through the understanding of how all services within the medical center provide sustenance for the clinicians has been one of the most significant improvements. For example, the Logistics Department is now staffed with 44 employees from the baseline of 14 employees. The allocation of resources and funding for this specific department demonstrates the Executive Leadership's dedication to funding the core services.

To ensure continued success the Washington DC VAMC has identified several additional core services that are key to the provision of the hospital's key business functions: Fiscal Service, Human Resources, Prosthetics, Environmental Services, the Business Office, and all the services who collaborate with the clinicians daily to ensure the overall delivery of health care services. The medical center is continuing its efforts to recruit qualified employees to work in all the vacancies in the medical center and they are engaging innovative and targeted tactics to complete this task. Specifically, the medical center has held two hiring events to fill Medical Support Associate positions, the most recent event hosted approximately 110 candidates to fill 40 vacancies. The

Business Office conducted all interviews in a highly successful two-day event that focused efforts, brought together colleagues, and highlighted the importance of this position in the overall success of the Washington DC VAMC's mission.

In reference to OIG Report No. 16-03576-53, *Health Care Inspection – Patient Mental Health Care Issues at a Veterans Integrated Service Network 16 Facility*, recommendations 1, 4, 7, and 9 are closed. The facility implemented a clinical appeals process and an admission screening process for the Psychosocial Residential Rehabilitation Treatment Program. Non-VA Care patient discharge lists are provided to the facility for follow-up of high-risk patients within 7 days of discharge. Patients discharged from VA facilities who are unable to be seen within 30 days of discharge at VA facilities are offered non-VA Care. The Health Treatment Coordinator Memorandum is in place. Compliance with the local facility policy on suicide behavior reports has been reinforced and audited. As recommended by OIG, peer reviews were conducted.

KEY RELATED LINKS:

- OIG Report, Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15, Report No. 17-00481-117, March 13, 2018.
- OIG Report, Health Care Inspection – Patient Mental Health Care Issues at a Veterans Integrated Service Network 16 Facility, Report No. 16-03576-53, January 4, 2018.
- OIG Report, Health Care Inspection – Opioid Agonist Treatment Program Concerns, VA Maryland Health Care System, Baltimore, Maryland, Report No. 16-01091-06, October 19, 2017.
- OIG Report, Audit of VHA's Management of Primary Care Panels, Report No. 15-03364-380, December 6, 2017.
- OIG Report, Review of Alleged Use of Inappropriate Wait Lists for Group Therapy and Post Traumatic Stress Disorder Clinic Team, Eastern Colorado Health Care System, Report No. 17-00414-376, November 16, 2017.
- OIG Report, Critical Deficiencies at the Washington DC VAMC, Report No. 17-02644-130, March 7, 2018.
- OIG Testimony, "VA Efforts to Prevent and Combat Opioid Overmedication," November 15, 2017.
- OIG Testimony, "VA Logistics Modernization: Examining the Real-Time Location System and Catamaran Projects," May 8, 2018.
- OIG Report, Evaluation of the Quality, Safety, and Value Program in Veterans Health Administration Facilities Fiscal Year 2016, Report No. 16-03743-193, March 31, 2017.
- OIG Report, Combined Assessment Program Summary Report: Evaluation of Moderate Sedation in Veterans Health Administration Facilities, Report No. 13-01743-192, May 2, 2013.

OIG CHALLENGE #3: BENEFITS DELIVERY

STRATEGIC OVERVIEW

Delivering accurate and timely benefits is central to VA's mission. VBA is responsible for overseeing the nationwide network of VA Regional Offices (VARO) that administer a range of Veterans benefits programs, including compensation, pension, education, home loan guaranty, vocational rehabilitation and employment, and life insurance. These programs are estimated to pay over $107 billion in claims to Veterans and their beneficiaries in FY 2018. The OIG performs audits and evaluations of Veterans' benefits programs, focusing on the effectiveness of benefits delivery to Veterans, dependents, and survivors to identify ways in which program operations and services can be improved. The *Veterans Appeals Improvement and Modernization Act of 2017* became law in August 2017 and is expected to improve the timeliness of appeals processing. VA is working to implement the amendments included in the Act by February 2019.

OIG SUB-CHALLENGE #3A: IMPROVING THE ACCURACY AND TIMELINESS OF CLAIMS DECISIONS AND APPEALS

Enhanced policies and procedures, training, oversight, quality reviews, and other management controls are necessary to improve the accuracy and timeliness of claims decisions. In May 2017, VBA implemented the Decision Ready Claims initiative to streamline claims processing and improve timeliness and quality. VBA expects that Veterans whose claims are processed under the Decision Ready program will receive a decision in 30 days. Still, VBA faces management challenges when its claims processing lacks compliance with procedures, which can increase the risk of improper benefits payments to ineligible recipients and not fully compensate eligible Veterans. For example, in FY 2018, the OIG raised concerns about the compensation and pension examination process for one of the signature wounds of the recent conflicts in Iraq and Afghanistan—traumatic brain injury (TBI). In particular, the training for individuals who conduct compensation and pension examinations for TBI lacks rigor, and the documentation of these TBI exam findings frequently is insufficient to identify the basis for the findings of a cognitive impairment(s) or the symptoms of TBI.

VBA also continues to struggle to process appeals in a timely manner. For example, in FY 2018, the OIG reported that VBA staff did not always promptly process benefit appeals. Generally, periods of inactivity occurred because (1) VBA senior leaders prioritized the rating claims backlog over appeals workloads and did not dedicate sufficient resources; (2) VBA had an ineffective procedure for notifying VAROs when they were required to process Board of Veterans' Appeals (Board) grants; (3) some appeals were prematurely closed because VBA staff failed to update, or incorrectly updated, the electronic system and relied on an automated function to close some appeals; and (4) VBA staff failed to follow the Board's remand

instructions due to inattention to detail and ineffective oversight. In some cases, delays caused by VBA resulted in appellants waiting years to receive favorable decisions and compensation. Delaying decisions also resulted in some appellants paying more of their benefits to accredited attorneys and agents, and some appellants died before receiving final decisions on their appeals. Processing errors also resulted in loss of control of some appeals, misrepresented VA's reported statistics, and caused unnecessary delays.

VA PROGRAM RESPONSE: OIG SUB-CHALLENGE #3A:

VBA provides claims processors with TBI training based on content created from procedural and regulatory guidance published in the Adjudication Procedures Manual (M21-1), 38 CFR Part 3, and 38 CFR Part 4, Subpart A: General Policy in Rating, and Subpart B: Disability Ratings. All training lessons are available through the Talent Management System, a computer-based training platform that ensures consistent material delivery to every trainee. In addition, VBA also provides training via virtual classroom and live classroom settings. During the period of October 1, 2017, through September 30, 2018, VBA claims processors completed 3,384 instances of TBI training totaling 9,200 hours.

The Veterans Health Administration Office of Disability and Medical Assessment (DMA) establishes compensation and pension examiner training requirements. Contract examiners who perform TBI examinations are required to complete the DMA TBI training module. VBA conducts quality reviews of completed contract examinations to ensure they are accurate, complete, and adequate to support VA disability rating decisions.

VBA's Pension Management Centers (PMCs) prioritize benefits reductions related to Medicaid-covered nursing homes to minimize improper payments. All PMCs have Workload Management Plans that address and prioritize pending reductions based on Medicaid-covered nursing homes, requiring daily or weekly reviews as part of supervisory and employee responsibilities. Additionally, VBA updated its procedural manual and training materials and provided training to PMC personnel on general medical examinations related to original pension claims.

VBA is committed to enhancing the oversight of the administration and operations of its appeals program to include improvements in quality and timeliness. In January 2017, VBA realigned its appeals policy and oversight of its national appeals operations under a single office, the Appeals Management Office (AMO). Appeals program administration matters, such as appeals-related training and quality assurance, now reside under the AMO, and the Appeals Resource Center (ARC) aligns under the oversight of the AMO Director.

Under the oversight of the AMO, VBA is employing several methods to manage, monitor, and assess resource allocation needs to ensure staffing is appropriate to address both legacy appeals and claims in the new process, once Public Law 115-55 becomes effective in February 2019, in a way that is fair to all claimants. To manage the appeals workload and to improve

timeliness of pending appeals, VBA brokers' appeals workload across the RO appeals teams are to be based upon capacity, focusing on the oldest pending appeals by stage. As part of the implementation of the *Veterans Appeals Improvement and Modernization Act of 2017*, VBA launched RAMP and developed a forecasting model to assess resource needs and initiate execution of a plan to re-distribute resources among legacy appeals, Higher-Level Review, and Supplemental Claim lanes, as needed, to process the latter two within the 125-day average processing goal and to accelerate the elimination of the legacy appeals inventory.

Launched on November 1, 2017, RAMP allows Veterans with pending disability compensation appeals in VBA with the voluntary option to participate in the new process during the implementation period. At the end of FY 2018, 10 RO appeals teams processed RAMP elections, while the remaining RO appeals teams continued to work legacy appeals. Lessons learned through RAMP inform VBA on staffing needs, resource allocation, workload capacity, processing timeliness, and work credit in the new process. Furthermore, effective October 1, 2018, VBA established three new Decision Review Operations Centers (DROCs): in Seattle, WA, St. Petersburg, FL, and the ARC in Washington, D.C. under the direct control and oversight of the AMO. The DROCs have the primary responsibility of processing requests for higher-level reviews of VA's decisions on compensation benefit claims under the new framework, all legacy and new process remands by the Board of Veterans' Appeals (Board), and Board grants of new process appeals. VBA will use the additional 605 full-time equivalent employees, approved in the FY 2019 budget, to staff these DROCs. VBA continues to utilize RAMP data, as well as current legacy processing data, to update its forecasting model to ensure it is properly resourced and maintain average timely processing goals, while simultaneously resolving the legacy appeals inventory as quickly as possible.

Regarding the OIG report on timely processing of appeals, OIG has closed three of the four recommendations. On September 24, 2018, VBA revised both the site visit protocol and the guidance in the M21-4 Manpower Control and Utilization in Adjudication Divisions, Chapter 5, on conducting Systematic Analyses of Operations on appeals processing. The revised site visit protocol ensures that the AMO assesses compliance with Board remand instructions and recertification of appeals to the Board through VBA's national site visit program. Moreover, the M21-4 revision ensures that regional office management routinely assesses compliance at the local level.

OIG SUB-CHALLENGE #3B: IDENTIFYING AND MITIGATING THE RISK OF DISABILITY-RELATED FRAUD, WASTE, AND ABUSE

VBA has a duty to identify and mitigate the risk of benefits fraud to protect the integrity of the program and ensure that Veterans receive their full and correct benefit entitlements at the right time. VA has launched the "Seek to Prevent Fraud, Waste and Abuse" (STOP FWA) initiative

that is expected to ensure a more consistent approach throughout VA to avert misconduct. As of June 8, 2018, the OIG opened 201 investigations involving the fraudulent receipt of VA monetary benefits, including deceased payees, fiduciary fraud, identity theft, and fraud by beneficiaries, which resulted in 119 arrests. The OIG also assisted the VA in obtaining over $11.3 million in court-ordered fines, restitution, penalties, and civil judgements; achieved over $20.9 million in savings, efficiencies, and cost avoidance; and recovered more than $5.9 million.

VA PROGRAM RESPONSE: OIG SUB-CHALLENGE #3B:

VBA is partnered with the United States Department of Treasury and external experts and consultants, such as Grant Thornton and McKinsey and Company, to strategically assess and identify opportunities to mitigate risks associated with fraud, waste, and abuse in all its programs. VBA is also receiving expert advice from a Federal Advisory Committee on improving and enhancing VA's efforts to identify, prevent, and mitigate fraud, waste, and abuse to improve the integrity of VBA's payments and the efficiency of VBA's programs while ultimately protecting our Veterans. Collaboration efforts from both internal and external partnerships resulted in VBA recently consolidating all fraud, waste, and abuse efforts under the VBA Office of Financial Management. VBA is developing a strategic plan to address, identify, and mitigate risks associated with all benefits payments. The prevention of fraud, waste, and abuse is not static and will require continued investment and effort to protect our Nation's Veterans, taxpayers' interests, and the integrity of the agency.

VBA currently utilizes contract support to create algorithmic programs to proactively identify fraudulent direct deposit changes, improper benefits payments in Compensation and Pension programs, as well as assisting State and Federal investigative agencies with evidence collection. The following are some of the team's major FY 2018 accomplishments. The team completed the initial analysis that identified $29 million in potential improper payments as a result of deceased Veterans, beneficiaries, and dependents not originally caught in the SSA Death Master file match. Full analysis to be completed by end of October 2018 to address full financial impact and will be reported to VBA leadership upon verification. The team developed a proactive algorithm that identifies over 70 percent of all fraudulent direct deposit changes before the Veterans know they were victims of fraud. The algorithms allowed VBA to proactively identify over 2,280 fraud cases, in which the team prevented or recovered over $2.2 million from being stolen from Veterans and the VA. The latest project is a Surety Bond Reclamation effort which utilizes $1.5 million in General Operating Expenses (GOE) funding to attempt recovery of over 250 outstanding Surety Bonds valued at over $23 million.

KEY RELATED LINKS:

- OIG Report, Health Care Inspection – Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for

Traumatic Brain Injury Compensation and Pension Examinations, Report No. 15-01580-108, February 27, 2018.
- OIG Report, Review of Timeliness of the Appeals Process, Report No. 16-01750-79, March 28, 2018.
- OIG Report, Review of Alleged Appeals Data Manipulation at the VA Regional Office, Roanoke, Virginia, Report No. 17-00397-364, December 5, 2017.
- OIG Report, Review of Claims Processing Actions at Pension Management Centers, Report No. 15-04156-352, November 1, 2017.
- Inventory of benefits fraud cases, "Office of Investigations Activities," Semiannual Report to Congress, Issue 79, October 1, 2017–March 31, 2018: 28–43.

OIG CHALLENGE #4: FINANCIAL MANAGEMENT

STRATEGIC OVERVIEW

Sound financial management is integral not only to ensuring the best use of limited public resources, but also the ability to collect, analyze, and report reliable data to inform resource allocation decisions. Addressing shortcomings in VA's financial management would improve stewardship of the public resources entrusted for VA's use. Each year, the OIG audits VA's consolidated financial statements, as required under the *Chief Financial Officer's Act*, and completes a mandatory review of VA's compliance with the *Improper Payments Elimination and Recovery Act* (IPERA). Further, the OIG performs audits and reviews of other programs and activities that assess VA's management of appropriated funds.

OIG SUB-CHALLENGE #4A: IMPROVING FINANCIAL REPORTING

The audit of VA's financial statements for FYs 2016 and 2017 as of September 30, 2017, identified six material weaknesses. A material weakness represents a deficiency or combination of deficiencies in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. Five material weaknesses were repeated from the prior year's audit and one was elevated from a significant deficiency. In April 2018, VA submitted a draft Corrective Action Plan to the financial statement contract auditors, which is currently under review. The plan was prepared to address the weaknesses and the deficiency found in the financial statement audit. Further, the VA was noncompliant with Federal financial management systems requirements and the United States Standard General Ledger at the transaction level under the *Federal Financial Management Improvement Act* and had a violation of the *Antideficiency Act*, which was subsequently reported to Congress. The deficiency involved VHA's use of Medial Support and Compliance funds to pay for Service-Oriented Architecture Research and Development

software instead of the congressionally mandated IT systems appropriation.

It is noteworthy that material weaknesses associated with VA's financial statements may adversely impact the Department's ability to provide accurate and timely financial information regarding higher-risk programs. For example, those weaknesses may adversely impact the accuracy of VA's FY 2017 detailed accounting submission to the Office of National Drug Control Policy. In addition, VA did not fully comply with the *Digital Accountability and Transparency Act of 2014 (DATA Act)* due to weaknesses in VA's existing financial management systems and internal controls. As a result, VA did not submit complete, timely, quality, and accurate financial and award data to USASpending.gov for the second quarter of FY 2017.

VA'S PROGRAM RESPONSE: OIG SUB-CHALLENGE #4A

Users are satisfied (or better) with VA's ability to provide secure and transparent interoperability of information and data.

VA concurs that our legacy financial system does not fully comply with the Federal Financial Management Improvement Act (FFMIA). To address this major challenge, VA is currently working on VA's FMBT effort to migrate to a new financial management system, iFAMS. VA's FMBT effort will increase the transparency, accuracy, timeliness, and reliability of financial information resulting in improved fiscal accountability to American taxpayers and offers a significant opportunity to improve care and services to our Veterans. The FMBT program goals capitalize on the opportunities for business process improvements to resolve systemic and procedural issues including:

- Standardizing, integrating, and streamlining financial processes, including budgeting, procurement, accounting, resource management, and financial reporting.
- Facilitating management that is more effective by providing stronger analytics and projections for planning purposes.
- Improving customer service and support of goods, supplies, and services for Veterans.
- Improving the speed and reliability of communicating financial information throughout the VA and providing timely, robust, and accurate financial reporting.

As VA modernizes our financial and acquisition systems, it will replace the financial management functionality of the IFCAP system and CAATS and the procurement functionality of eCMS. The FMBT effort will resolve many of VA's current areas of noncompliance with FFMIA and address many of the deficiencies related to the material weaknesses and significant deficiency on Undelivered Orders.

In addition, VA has initiated targeted actions to address the material weaknesses and significant deficiencies reported in the FY 2017 Consolidated Financial Statements Audit. Specifically, the VBA has hired a certified actuary in early FY 2018 that, along with the existing actuarial contract support for both education and compensation benefits. For Loan Guarantee, VBA has updated the re-

estimate models and is obtaining an independent review of the results.

The OCC has issued a new Financial SOP on May 03, 2018 for the major business and financial processes of VHA Community Care. The developed SOPs support the key processes within Community Care including Cost Estimation, Obligations, Authorizations, Batch Processing, and Reconciliations.

To address the internal control material weakness noted for the reconciliation discrepancies between Fee Basis Claims System (FBCS) and FMS, VA collaborated and developed an automated solution for the OCC categories of care reconciliation processes. The FBCS to FMS Variance Dashboard was created to automate the calculation for all major categories of care, which will bring structure, standardization, and increased visibility to the back-end reconciliation process. Also, VHA kicked off Obligate and Pay training in August and continued through mid-September to assist with implementing the new FY 2019 obligate and pay methodology for VHA Community Care funds. Obligate and Pay will eliminate the inconsistent obligation estimates against the program and help eliminate the material weakness.

In addition, to mitigate the lack of consistent reconciliation between IFCAP and FMS, VHA has taken measures to train and require the field offices to perform monthly IFCAP to FMS reconciliations using exiting reporting tools in VistA and FMS.

To address the material weakness around financial reporting, VA identified and implemented a standardized approach to performing quarterly financial statement variance analysis and monthly abnormal balance reviews. As the variance and abnormal balance analyses and supporting research are now more thoroughly developed, the Administrations are identifying the root causes that drive abnormal balances and the actions needed to correct them, as well as providing well-developed explanations to address material variances.

The Administrations and program offices are actively engaged and working to continuously improve and strengthen internal controls in financial management. VHA and the Financial Services Center (FSC) worked collaboratively to strengthen the Inter-Agency Agreement (IAA) process, specifically working with the field to ensure IAAs are in the FSC repository. VHA and FSC provided training to the field on completing correct and valid IAAs to include the FSC repository/approval process.

OIG SUB-CHALLENGE #4B: REDUCING IMPROPER PAYMENT RATES

VA faces significant problems in reducing improper payment rates, evidenced by a recent significant increase in improper payments. In particular, VA reported improper payment estimates totaling $10.7 billion in its FY 2017 AFR, almost twice the FY 2016 reported amount of $5.5 billion. The net increase is primarily the result of the VHA adding three programs susceptible to significant improper payments to the AFR as well as reporting higher improper

payments for five VHA and three VBA programs.[23]

VA met four of six IPERA requirements for FY 2017, though VA did not fully comply with the remaining two reporting requirements.

Specifically, VA did not perform the following:

- Report a gross improper payment rate of less than 10 percent for seven of 13 programs and activities that had an improper payment estimate in its FY 2017 AFR. Further, 2 of the 7 programs have exceeded the 10 percent threshold for 3 consecutive fiscal years. The two programs' improper payments were primarily due to administrative or process errors, insufficient documentation, or noncompliance with Federal Acquisition Regulation (FAR) requirements.
- Meet annual reduction targets for seven programs and activities. In addition, four of the seven programs have not met reduction targets for 3 consecutive fiscal years. These four programs' improper payments were primarily due to administrative or process errors, insufficient documentation, or noncompliance with FAR requirements.

VA also faces serious impediments to preventing improper payments under the Veterans Choice Program, one of several programs through which Veterans may receive VA-funded care from community providers. For example, the OIG determined that an estimated 224,000 of the 2 million Choice claims sampled were paid in error. Weak internal controls over the payment process, the lack of clear written policies for Choice claim payments, information system limitations, and staffing inadequacies contributed to these errors. As a function of these errors, VA made an estimated $39 million in overpayments to the third-party administrators that process claims and pay Choice medical providers. VA has developed an action plan to improve the timeliness and accuracy of Choice payments. For example, VHA now requires that TPA continually review payments for accuracy. In addition, VHA is utilizing an automated internal assessment tool to detect and prevent duplicate payments prior to payment. The OIG has continued to monitor VA's progress.

VA PROGRAM RESPONSE: OIG SUB-CHALLENGE #4B

VA is committed to obtaining compliance with IPERA. Since 2015, VA reported increases in improper payment rates due to the continued improvement of testing surrounding acquisitions. This increased

[2] As reported in the FY 2016 AFR, VA identified Communications, Utilities, and Other Rents; Medical Care Contracts and Agreements; and Prosthetics were susceptible to improper payments due to noncompliance with contract requirements VA identified while conducting its risk assessments.

[3] The eight programs primarily lacked sufficient documentation or encountered administrative or process errors that caused the majority of the improper payments.

improper payment rate has continued into 2018 as VA continues to implement the VA Office of Acquisition, Logistics, and Construction (OALC) 2017 guidance to ensure consistent testing in acquisition for IPERA compliance.

Most improper payments in VHA were caused by insufficient documentation to support contract payments and do not represent an actual monetary loss to the Government. In FY 2017 reporting, VHA found that most programs need to increase compliance with procurement processes to improve improper payment rates. VHA developed 57 corrective actions to assist in reducing the improper payment rates, and, as of July 2018, through partnership with acquisition personnel when appropriate, 32 corrective actions have been successfully implemented.

VA has made multiple improvements to improve the accuracy of payments in its VHA programs providing care to Veterans. The OCC began utilizing an electronic tool with advanced data analytic capabilities to identify duplicate payments prior to issuing Choice expedited payments. Since July 2017, potential duplicate payments totaling more than $71.1 million have been prevented using this tool. In addition, both pre- and post-payment duplicate analyses have been implemented by the VA FSC for all Choice payments it processes through its claims processing software. VHA is also working to implement a new automated reimbursement system for processing invoices for the future state Community Care Network contracts. The new system will incorporate Fraud, Waste and Abuse tools, data analytics, and financial measurement functionality. Prepayment analytics will provide for identification of duplicate claims, out of network provider claims, and alert when providers are included in the Federal List of Excluded Individuals and Entities database.

VBA is also collaborating with the SSA and the Internal Revenue Service (IRS) to rely less on Veteran reported information. VA will initiate steps in performing computer-based data matches utilizing Federal Tax Information (FTI). Transactions will be based on the most current information received from SSA and IRS, helping reduce improper payments. Lastly, OIG reported a repeat finding the last 2 years related to the concurrent payment of VA benefits and drill pay. To address root causes of improper payments, as previously reported, VBA established a collaborative working group in FY 2015 with members of the DoD to work toward a solution to move the current annual drill pay adjustment process to a monthly process. VBA drafted a proposed rule, currently in the concurrence process, to permit VA to suspend disability compensation payments upon receipt of notice from the Veteran or DoD that the Veteran has received, is receiving, or will begin to receive active service pay. While VBA continues to address these findings from OIG, VA has not identified improper payments related to drill pay since FY 2014.

OIG SUB-CHALLENGE #4C: IMPROVING MANAGEMENT OF APPROPRIATED FUNDS

The importance of appropriately, consistently, and transparently executing appropriations cannot be overstated, as this helps to ensure that VA programs, services,

and benefits are supported in the manner that Congress intended. However, in FY 2018, the OIG documented several instances of mismanagement of appropriated funds. For example, VA misused approximately $9.6 million from the General Operating Expense appropriation, $3.1 million from the Medical Support and Compliance appropriation, and $5.2 million from the Medical Services appropriation to finance information technology development costs. Further, VA was delinquent in reimbursing the Treasury Judgment Fund in accordance with applicable regulations for claims arising out of major contract disputes. By not reimbursing the Judgment Fund promptly, VA has continued to maintain significant liabilities not covered by budgetary resources.

VA'S PROGRAM RESPONSE: SUB-CHALLENGE #4C

The VA understands the significance of its responsibility to appropriately, consistently, and transparently execute funding for VA programs, services, and benefits as Congress intended. In doing so, VA relies on findings and recommendations identified within the audit, improper payments, and other compliance reporting. In support of financial stewardship, the VA CFO signed the VA CFO Council Charter on March 9, 2018, formally establishing an advisory committee for fiscal decisions and recommendations related to programming, budgeting, capital asset management, internal controls, financial operations, and financial policy. The VA CFO Council consists of representatives from the VA Administrations and Staff Offices at the CFO leadership level and advises the VA CFO on the Department's strategic approach for improvements in financial management and ways to achieve integration with organizations across VA.

To address concerns related to financial stewardship of information technology resources, the Department issued VA Directive 6008, Acquisition and Management of VA Information Technology Resources. The Directive was published on November 2, 2017, and established the following requirements:

- Identifies the types of IT and Non-IT purchases and software development activities that VA routinely conducts, in addition to the correct Congressional Appropriation to use.
- Establishes the IT/Non-IT Workgroup as an official means of resolution, such as when VA staff are unsure of the correct Congressional Appropriation to use when making an IT-related acquisition. Workgroup decisions provide a proactive means of regularly updating guidance to accommodate the rapid advances in IT technology used in VA.

Additionally, the VA CFO Council modified the IT/Non-IT Workgroup Charter to escalate IT/Non-IT funding decisions to the VA CFO Council for final decision if the Workgroup cannot reach consensus. The modified IT/Non-IT Workgroup Charter was signed by the VA CFO on July 12, 2018.

In terms of the Treasury Judgement Fund, VA recently closed the report *Review of VA's Reimbursement to the Treasury*

Judgment Fund (Report No. 17-00833-05, Issued November 28, 2017, by establishing the recommended procedures to ensure VA reimburses the Treasury Judgment Fund within 45 business days of receipt of requests for reimbursement or establishes appropriate payment plans for claims paid pursuant to applicable law. In doing so, VA updated its Financial Policy Volume III, Chapter 11 – Reimbursements to Judgment Fund to reflect the requirements contained in Treasure Policy and 31 CFR 256.40 and 256.41. As specified in the charter, VA Financial Policy decisions are also within the scope and responsibilities of the VA CFO Council.

KEY RELATED LINKS:

- OIG Report, Audit of VA's Financial Statements for Fiscal Years 2017 and 2016, Report No. 17-01219-24, November 15, 2017.
- OIG Report, Independent Review of VA's FY 2017 Detailed Accounting Submission to the Office of National Drug Control Policy, Report No. 18-00836-147, March 26, 2018.
- OIG Report, Audit of VA's Compliance With the DATA Act, Report No. 17-02811-21, November 8, 2017.
- OIG Report, VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017, Report No. 17-05460-169, May 15, 2018.
- OIG Report, Audit of VHA's Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System, Report No. 15-03036-47, December 21, 2017.
- OIG Report, Alleged Contracting and Appropriation Irregularities at the Office of Transition, Employment, and Economic Impact, Report No. 16-04555-138, May 2, 2018.
- OIG Report, Review of Alleged Funding Security Issues of the Veterans Services Adaptable Network at VA Medical Center Orlando, Florida, Report No. 15-03059-384, January 31, 2018.
- OIG Report, Audit of VHA's Use of Appropriations to Develop a System Enhancement and Mobile Health Applications, Report No. 15-01005-18, January 17, 2018.
- OIG Report, Review of VA's Reimbursements to the Treasury Judgment Fund, Report No. 17-00833-05, November 28, 2017.

OIG CHALLENGE #5: PROCUREMENT PRACTICES

STRATEGIC OVERVIEW

To facilitate departmental operations and the delivery of medical care and benefits to Veterans, VA procures tremendous quantities of goods and services from vendors through contracts and purchase card payments. Thus, it is imperative that VA has effective controls over procurement actions. To assist in that effort, in FY 2018, the OIG conducted oversight of procurement practices through pre- and postaward contract reviews, program reviews, and investigations.

OIG SUB-CHALLENGE #5A: IMPROVING CONTRACTING PRACTICES

VA continues to have important opportunities for contract-related cost savings and recoveries, which the OIG identifies through pre- and postaward contract reviews. For example, VA contracting officers struggled to negotiate fair and reasonable contract prices and to ensure price reasonableness during the terms of contracts. Through 44 preaward reviews, the OIG identified nearly $533 million in potential cost savings, including $27.8 million in potential cost savings related to health care provider proposals. During the same period, through postaward contract reviews, some of VA's vendors were determined to be noncompliant with contract terms and contracts. To that end, the OIG completed 21 postaward reviews that resulted in $9.1 million in recoveries of contract overcharges. VA also continues to struggle with construction project management, which contributed to delays and cost overruns for a new surgical intensive care unit and an expanded operating room suite at a VA medical facility. Further, several company owners were recently convicted of fraudulently receiving multimillion dollar contracts intended for service-disabled Veterans.

VA'S PROGRAM RESPONSE: SUB-CHALLENGE #5A

The OALC has an established procedure for pre-and postaward reviews, which are currently performed by the OIG, to ensure cost-effective and compliant VA Federal Supply Schedule (FSS) and other types of contracts are awarded and administered properly. Preaward and postaward reviews are performed when an offer or contract meets the established dollar threshold, when irregularities are found, or as required by Public Law 102-585, Veterans Health Care Act of 1992 (pertains to covered drugs). Once the review is completed, the OIG recommendations are considered and used in negotiating contract pricing and determining an award. With post-award reviews, a settlement is negotiated to recover any overcharges. This practice has been in place for over 38 years and will continue as long as the VA FSS program is viable.

To address OIG's concern regarding construction project delay and cost overruns for a new surgical intensive care unit and an expanded operating room suite at a VA medical facility, on February 13, 2018, VA Central Office (VACO) issued a memorandum to Oklahoma City requesting the facility implement procedures to strengthen minor and non-recurring maintenance construction oversight. Additionally, VACO requested that Oklahoma City establish procedures to ensure recommendations by technical experts, who perform site visits to evaluate project completion status and conformance to contract specifications as provided in design and construction contracts, are implemented. The VHA Office of Capital Asset Management Engineering and Support has been working with the facility to ensure compliance.

OIG SUB-CHALLENGE #5B: IMPROVING PURCHASE CARD PRACTICES

VA faces barriers to ensure that purchase cardholders are following applicable laws and regulations, including avoiding making split purchases—breaking up transactions to avoid exceeding the micro-purchase threshold—and only using the cards to purchase goods and services for which there is a bona fide need. During a review of VISN 15 purchase card practices, the OIG determined that purchase cardholders made 18 split purchases valued at approximately $73,000 when placing orders with a vendor with an expired contract. This occurred, at least in part, because of confusion among cardholders regarding what constituted a split purchase. In response to these deficiencies, VA is developing additional training to identify split purchases and how to avoid them. Also, VA plans to develop an audit tool to identify potential split purchases.

In addition, an OIG-led investigation of purchase card payments by a former VA medical facility supervisor identified nearly $452,000 in payments for unnecessary maintenance work, some of which were kicked back to the former supervisor. One of the former vendors pled guilty to blackmail; the other vendors and the former VA supervisor previously pled guilty to related charges and were sentenced.

VA'S PROGRAM RESPONSE: SUB-CHALLENGE #5B

VA continues to refine and improve its purchase card program and associated purchase card practices and oversight. As previously identified, VA is developing additional training to identify split purchases, as well as internal controls for how to avoid them. The Office of Management recently updated Financial Policy *Volume XVI, Chapters 1A, 1B, and 1C – Charge Card Programs* in June 2018 to address and clarify the split purchase definition, including examples. The VA FSC Charge Card Services Division worked with the FSC Data Analytics Division to develop an online audit dashboard to identify clusters of purchases made by one or more purchase cardholder at the same VA station, to the same type of merchant, to support the timely identification of potential split purchases.

Reducing and eliminating fraud by purchase cardholders is a key objective of the VHA purchase card program. Most purchase card fraud is identified through the OIG hotline by coworkers; however, the purchase card approving official should be able to identify fraud much sooner. VHA will improve communication to the thousands of VHA approving officials with instructions that include red flags to identify potential fraud and what to do if fraud is suspected. Split requirements are rarely fraud but are a shortcut that circumvents Federal regulations and VA policy to expedite the mission. The approving official is the key to reducing and eliminating split requirements and reducing the risk of fraudulent purchases.

Another primary issue with purchase cards is that, due to the lack of a robust Medical/Surgical Prime Vendor program and non-utilization of the current program, there is an over-reliance on purchase card usage to support medical centers. VHA is

currently working to identify approximately 37,000 items to be added to the Medical/Surgical Prime Vendor contract by the Strategic Acquisition Center. Additionally, there is an effort to create a single searchable catalog of all items available by contract that will be provided to purchase card holders. Having more items on contract that are easily identifiable will reduce improper purchase card use and transactional volume. The reduction in volume will increase the capacity of approving officials and to provide oversight.

In reference to OIG Report No. 15-05519-377, *Review of Potential Misuse of Purchase Cards at Veterans Integrated Service Network 15*, only one recommendation remains open. VISN 15 submitted ratification requests to the VHA Head of contracting activity. VISN 15 conducted additional focused training for its purchase cardholders and approving officials.

KEY RELATED LINKS:

- "Office of Contract Review Activities," Semiannual Report to Congress, Issue 79, October 1, 2017–March 31, 2018: 46.
- "Service-Disabled Veteran-Owned Small Business Fraud," Semiannual Report to Congress, Issue 79, October 1, 2017–March 31, 2018: 28.
- "Construction Company Owners Enter into Agreement with Government," Semiannual Report to Congress, Issue 79, October 1, 2017–March 31, 2018: 35.
- OIG Report, Review of Potential Misuse of Purchase Cards at Veterans Integrated Service Network 15, Report No. 15-05519-377, October 26, 2017.
- "Former VA Vendor Pled Guilty to Blackmail," Semiannual Report to Congress, Issue 79, October 1, 2017–March 31, 2018: 32.

OIG CHALLENGE # 6: INFORMATION MANAGEMENT

STRATEGIC OVERVIEW

VA IT infrastructure is essential to VA's delivery of medical care and benefits to Veterans. Secure information technology systems and networks for safeguarding that information and supporting the range of VA mission-critical programs and operations is critical. The *Federal Information Security Management Act* (FISMA) requires that agencies and their affiliates, such as Government contractors, develop, document, and implement an organization-wide security program for their systems and data. In FY 2018, the OIG completed audits and programs to review the extent to which VA had appropriate information technology safeguards in place.

OIG SUB-CHALLENGE #6A: ENSURING EFFECTIVE INFORMATION SECURITY PROGRAM AND SYSTEM SECURITY CONTROLS

Although VA has made progress producing, documenting, and distributing policies and procedures as part of its program, VA continues to face hurdles implementing components of its agency-wide information

security risk management program to meet FISMA requirements. Significant deficiencies persist related to access, configuration management, and change management controls, as well as service continuity practices designed to protect mission-critical systems from unauthorized access, alteration, or destruction. VA must prioritize remediation of these deficiencies, as ongoing delays in implementing effective corrective actions may contribute to the continued reporting of an information technology material weakness in VA's financial statements.

VA'S PROGRAM RESPONSE: SUB-CHALLENGE #6A

VA is committed to the protection of Veteran information and data with the use of tactical and strategic cybersecurity-related actions. Through these actions, VA continues to maintain a cybersecurity ecosystem capable of responding to identified risks. In alignment with Executive Order 13800, "Strengthening the Cybersecurity of Federal Network and Critical Infrastructure," the VA established the Enterprise Cyber Security Program (ECSP). This program identifies and manages cyber security projects to address tactical findings, OIG-related deficiencies, and strategic goals and objectives.

At present, the VA is working 39 ECSP Cybersecurity Projects to address these deficiencies. Among these projects are 30 projects directly tied to the FY 2017 OIG FISMA Audit recommendations, with the remaining nine projects addressing various other tactical and strategic capabilities. Using the ECSP governance and management apparatus, we have established accountable offices responsible for delivery of each of the 39 projects, and we have the means to persistently assess the status of each project until closure. These activities address a full spectrum of security-related capabilities, including: Security Management Programs, Identity Management and Access Controls, Configuration Management, System Development and Change Management, Contingency Planning, Incident Response and Monitoring, Continuous Monitoring, and Contractor Systems Oversight. With the completion of each project, the VA is directly addressing the component attributes and overarching requirement germane to the OIG's identified findings. At present, the VA is confident all project milestones and due dates will be finalized by September 30, 2018, with varying project completion dates occurring from now until March 31, 2019.

KEY RELATED LINKS:

- OIG Report, VA's Federal Information Security Modernization Act Audit for Fiscal Year 2017, Report No. 17-01257-136, April 11, 2018.
- OIG Report, Review of Alleged Unsecured Patient Database at the VA Long Beach Health Care System, Report No. 15-04745-48, March 28, 2018.
- OIG Report, Review of Alleged Funding Security Issues of the Veterans Services Adaptable Network at VA Medical Center, Orlando, Florida, Report No. 15-03059-384, January 31, 2018.