DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Department of Veterans Affairs

Fiscal Year 2019 Inspector General's Report on VA's Major Management and Performance Challenges

The mission of the Office of Inspector General is to serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs through independent audits, inspections, reviews, and investigations.

Each year, pursuant to 31 USC § 3516(d), the VA Office of Inspector General (OIG) provides VA with an annual update summarizing serious management and performance challenges identified by OIG work, as well as an assessment of VA's progress in addressing those challenges, which is then published in VA's annual Agency Financial Report. This update was also published in VA's fiscal year 2019 Agency Financial Report, section III, pages 177 through 224, in November 2019. Some minor edits were made to correct errors and for style consistency.

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FOREWORD

The Office of Inspector General's (OIG) mission is to serve veterans, their families, caregivers, and the public by conducting effective oversight of the Department of Veterans Affairs (VA) programs. 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. Each year, the Inspector General provides VA with an annual update summarizing serious management and performance challenges identified by OIG work, as well as an assessment of VA's progress in addressing those challenges.

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. Six areas were identified through OIG's oversight of the VA: (1) Strengthening leadership and workforce investments, (2) Improving health care access and quality of care, (3) Ensuring the accuracy and timeliness of benefits services, (4) Enhancing financial management and controls, (5) Overseeing the compliance and integrity of procurement practices, and (6) Minimizing risks and increasing effectiveness for information management systems.

The OIG conducts extensive oversight of VA programs and operations in each of these six areas through independent audits, inspections, investigations, and reviews. The OIG recognizes the Veterans Health Administration has the largest integrated public health system in the nation with prodigious changes underway for enhancing care, including expanding community care; implementing a new electronic health records system; and modernizing core systems—all while tackling veteran suicide, the opioid crisis, and other vital issues. The Veterans Benefits Administration implements a massive and complicated benefits system challenged by changes in technology and in its claims and appeals processes. In addition, the National Cemetery Administration strives to deliver services and benefits in a compassionate and efficient manner. Each of these administrations requires stable leadership throughout its organization, adequate numbers of trained qualified staff, and effective quality assurance.

While primarily focused on these significant challenges, OIG continues to see deficiencies in these and other key areas. This report recognizes where significant progress has been made and commends all VA leaders and personnel who have identified challenges and promotes high-quality services and benefits to the nation's veterans and their families.

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Inspector General

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OIG CHALLENGE 1: STRENGTHENING LEADERSHIP AND WORKFORCE INVESTMENT

STRATEGIC OVERVIEW

As in prior years, VA faces significant challenges in carrying out its mission to serve veterans, due in large part to leadership and workforce investment issues. These difficulties are exacerbated by the Department's size and complexity of operations. For fiscal year (FY) 2019, VA is operating under a $201.1 billion budget and is the second-largest federal employer, with more than 380,000 employees serving an estimated 19.6 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 an integrated healthcare system that has approximately 9 million enrolled veterans.

VA is making efforts to address many of the challenges it faces. An example is VA's reported intention to become a High Reliability Organization (HRO) through efficiencies in three main areas: (1) committing to improve safety and reliability through leadership's vision, decisions, and actions; (2) implementing a culture of safety in which values and practices are used to prevent harm and to learn from mistakes; and (3) using effective tools that continuously improve the organization. VA has also reported modifying its human resources (HR) information system, HR Smart, to have a more accurate picture of position counts and vacancies, with tools for improved healthcare provider recruiting and retention consistent with the VA MISSION Act.

Still, the need for continued improvement in several areas is evident, as noted in OIG reports published over the past fiscal year. As discussed below, OIG oversight has revealed three key areas of concern related to leadership and workforce development:

- A culture of complacency or lack of personal responsibility to effect meaningful change is a common contributing factor to deficiencies in VA facilities and program offices. While strong leadership and governance can help address climate issues, it must be infused into all workforce development efforts;
- Unstable leadership and vacancies or temporary assignments to key positions are often at the heart of persistent problems facing VA; and
- Staffing shortages and inadequate staff development also continue to undercut many VA efforts to properly manage its systems, programs, and services.

To assist VA in making needed improvements, OIG has prioritized oversight in each of these areas.

OVERCOMING A CULTURE OF COMPLACENCY

Although VA employs many talented and committed people, one of the greatest obstacles to sustained advancement is the sense of resignation among some employees and leaders that identified problems will not be redressed.

This is manifested in failures to report wrongdoing, broken systems or processes going unaddressed for long periods, and nonengagement in problem-solving and change implementation. For example, in the OIG report on *Falsification of Blood Pressure Readings at the Danville Community Based Outpatient Clinic in Salem*, Virginia, a primary care provider was found to have falsified information in patients'

medical records for several years. Specifically, the care provider documented patients' blood pressure readings as 139/89 more than 30 percent of the time reviewed (just below a threshold that would have required follow-up), including for high-risk patients diagnosed with hypertension, diabetes, or atherosclerotic cardiovascular disease. The OIG review demonstrated that leaders and staff knew of the misconduct but did not take appropriate action. The chief of staff did not thoroughly review the allegations after being contacted by the OIG twice in 2018, and employees who had knowledge of the allegations as early as 2016 also failed to act.

Similarly, in *Orthopedic Surgery Department and Other Concerns at the Carl T. Hayden VAMC in Phoenix, Arizona*, the OIG describes long-standing accountability issues among VA medical center (VAMC) orthopedic surgery department staff, including how that department tolerated on-call surgeons who did not consistently manage complex patient care needs and relied on physician assistants to find other surgeons to care for patients, resulting in potential care delays.

These two recent OIG reports echo the types of concerns raised in *Critical Deficiencies at the Washington DC VAMC*—a seminal report that describes the breakdown of systems and leadership at multiple levels and an acceptance by many personnel that circumstances will never change. While that facility has shown progress in several areas, there are 12 recommendations that remain unimplemented more than a year following the report's issuance, as described in a June 2019 OIG congressional testimony on "Ensuring Quality Health Care for Our Veterans." Further, the persistence and pervasiveness of these types of issues contributed to the Comptroller General's decision to continue to include VA health care on GAO's High-Risk List.

VA'S PROGRAM RESPONSE

Estimated Resolution Time Frame: Ongoing

Responsible Agency Official: Secretary of Veterans Affairs

In April 2019, the Secretary signed the first-ever VA-wide Employee Engagement (EE) Plan, which provides strategic direction to guide EE efforts across the Department.

VHA achieved a 63.9 percent response rate for the 2019 VA All Employee Survey (AES), which is up 2.3 percent from last year. In 2017, the VHA response rate was 59.5 percent. This steady increase in response rate is a good indicator of improved EE. We saw improvements in 2018 AES data on items related to culture of complacency. This fiscal year we gathered EE best practices from sites that showed significant improvement in that metric from 2017 to 2018. This fiscal year, targets related to AES data sharing and data use were included in SES performance plans throughout VA to encourage the involvement of employees at all levels in improvement processes.

In response to the recommendations for OIG 18-05410-62, *Falsification of Blood Pressure Readings at the Danville Community Based Outpatient Clinic*, the OIG closed recommendations 1 and 5.

Recommendations for items 2–4 remain open.[1] All patients potentially impacted were contacted and care provided if needed. The facility has instituted a review of VHA Support Service Center data as part of Ongoing Professional Peer Evaluation cycles. The facility continues to monitor for unusual patterns in patient clinical data.

[1] References to open recommendations throughout this report were as of the time of writing for the issuance of VA's Agency Financial Report in November 2019.

We have created a standard operating procedure (SOP) in the Primary Care Service for data exchange with Community Based Outpatient Clinics (CBOC), as well as a standardized reporting structure between the Primary Care Service, CBOCs, and the Salem VAMC. All Contracting Officer Representatives (COR) at the Salem VAMC have received training and re-education.

In reference to the Phoenix report on Orthopedic Surgery, clinical leadership conducted a review on all aspects of decision-making and care provided to Patients X and Y on March 11, 2019. Leadership determined all aspects of the decision-making and care were appropriate for the patients. An Institutional Disclosure was conducted with Patient X's next of kin on July 31, 2019. On March 7, 2019, the Orthopedic Section implemented the "On-Call Protocol for Orthopedic Surgery" to clarify the on-call relationship between physician assistants and the orthopedic surgeons. Surgery leadership took appropriate action on the letter of expectation issued to Surgeon A (former Chief of Orthopedics). In January 2019, the Surgery Service developed an SOP for scheduling add-on surgical cases, including after-hours "emergency" cases in the operating room (OR). The six recommendations from the Veterans Integrated Service Network (VISN) Site Visit were implemented for the Anesthesia program operations. Construction was approved in August 2017 to address the Sterile Processing Service (SPS) space constraints that limit capacity, and productivity is in the design phase. SPS implemented the CensiTrac Instrument Tracking System on March 11, 2019. In February 2019, Surgery Service updated the core privileges for orthopedic surgery to reflect procedures performed. Policy 11-118, Utilization of Physician Assistants, was signed by the Medical Center Director on August 8, 2019, and published.

With support from VISN 5 and VHA, the Washington, DC VAMC has worked tirelessly to address the Critical Deficiencies report. The organization has developed, revised, and updated policies and procedures to ensure compliance with regulatory bodies, standards of practice, and standards of care. The organization has reviewed and updated their governance structure. Committees and councils that provide oversight to the departments and report to leadership have been reinstituted. Policies and procedures are in place to ensure that supplies, instruments, and equipment are available throughout the Medical Center when needed. Weekly rounds have been implemented by logistics and SPS to Performance and Accountability report levels, wall-to-wall inventories, utilization of Generic Inventory Package, Prime Vendor Utilization, utilization of AEMS/MERS system, inventory and reconcile warehouse items, conduct quality checks in SPS, implement tracking systems for equipment in SPS, and replace broken or missing instruments. Multidisciplinary OR huddles have been implemented to improve communication between the OR and SPS.

The DC VAMC has also worked diligently to provide education and training to staff regarding new and revised policies and SOPs, the governance structure, newly implemented systems and programs, privacy, records management, and other programmatic changes. The Medical Center also worked with Fiscal, Logistics, Prosthetics and other services to return clinical purchases to Logistics, to improve fund controls, accountability of purchases, and segregation of duties. Funds have been made available for Prosthetics to ensure that services are not stopped for veterans. As of August 7, 2019, 31 of 40 (78 percent) of the Critical Issues have been accepted for closure, including 28 recommendations closed during FY 2019.

VHA has committed to becoming an HRO, building upon lessons learned from existing HRO efforts within VHA and other health care systems. VHA will train, educate, and coach all leaders and staff in high reliability principles and practices. HRO transformation will impact the entire organization from health system leaders to care teams as we redouble our focus on safety to create an enterprise-wide Just Culture of greater reliability and "Zero Harm."

Five Principles of HROs

HRO principles strive to turn psychologically unsafe cultures of complacency into Just Cultures:

1. **Sensitivity to Operations**. Staff maintain situational awareness of how their decisions may impact system performance.
2. **Reluctance to Simplify**. Staff apply data and systems thinking to challenge assumptions and identify the multiple causes of a problem.
3. **Deference to Expertise**. The organization places decision-making authority in the right hands.
4. **Preoccupation with Failure**. Employees are rewarded for anticipating risks, identifying problems, and sharing mistakes requiring system improvements.
5. **Commitment to Resilience**. Staff is trained to respond to errors quickly, contain them, and learn from them.

HROs in aviation, energy, advanced manufacturing, and health care avoid catastrophic events of harm and continually improve performance, despite operating in environments with significant hazards and complex time-sensitive processes. Health care organizations have a special responsibility to assure the safety of their patients and employees; a health care HRO delivers consistently safe and reliable health care in a culture where high-reliability principles and practices span the entire organization.

ADDRESSING KEY LEADERSHIP VACANCIES AND OTHER STAFFING SHORTAGES

The root cause of many issues identified in OIG oversight reviews was poor leadership, vacant and temporary key positions, and staffing shortages. In the past year, VA filled such key positions as VA Secretary, Assistant Secretary for Human Resources and Administration, and Assistant Secretary for the Office of Information and Technology (OIT). Yet many vital positions are still without a permanent leader. As of July 1, 2019, VA had been without a permanent leader for VHA for more than 28 months; had an Acting Deputy Secretary for nearly a year; and [at this writing] had an Acting General Counsel.[2] At program offices and VA facilities, these challenges affect governance and performance—often manifesting as confusion about roles and responsibilities for critical functions, lack of personnel to timely complete needed tasks, and inaction on persistent problems.

For example, the OIG report *Inadequate Governance of the VA Police Program at Medical Facilities* describes how VA's police program has a splintered governance structure to oversee the federal law enforcement officers who secure facilities and protect patients, visitors, employees, and VA property. VA lacks an effective staffing model to determine the appropriate number and composition of the police force at each medical facility. This is concerning because the lack of facility-appropriate police staffing models, coupled with police officer shortages at VAMCs, can affect security activities such as the frequency and location of patrols. Similarly, in *Alleged Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center in New York*, the OIG notes ongoing challenges to maintain baseline nurse staffing levels, which facility leaders sought to address through floating assignments and overtime.

[2] This OIG report was part of the VA's overall annual report issued in November 2019. To increase transparency of OIG activities, it has been extracted and posted on the OIG website.

In five years of publishing the determination of VHA occupational shortages, the OIG has noted serious and persistent concerns with staffing. In response to requirements set out in the VA Choice and Quality Employment Act of 2017 (the Choice Act), the most recent iteration of this recurring report included staffing levels and identified shortages at the facility level. Among the occupations with the most frequently cited shortages were medical officers, nurses, HR managers, and police officers. The 2018 survey highlights the need for staffing models that identify and prioritize staffing needs at the national level while allowing flexibility at the facility level. The OIG has made recommendations related to the development and implementation of such staffing models in each of its previous staffing determination reports.

Staffing for future needs requires hiring in anticipation of future losses, as well as ongoing and projected changes in demand, staffing productivity, and staff allocations.

The OIG recognizes that VHA has made progress in implementing staffing models in primary care and inpatient nursing and that actions are underway to codify updated position categories to enable VHA facilities to more precisely define their clinical and nonclinical staffing requirements. However, considerable work remains to inform staffing requirements at the enterprise level and to facilitate national recruitment efforts and budget formulation.

VA'S PROGRAM RESPONSE

Estimated Resolution Time Frame: 2021

Responsible Agency Official: Assistant Secretary for Human Resources and Administration/Office of Security and Preparedness

Every large organization will have what appears to be many vacancies due simply to normal retirements and job changes, but VA strives for full staffing capacity. Full staffing capacity refers to the number of personnel needed at a point in time to accomplish VA's mission to care for veterans and their families with dignity and respect. Full staffing capacity requirements change over time and are updated based on new business and workload requirements. Key drivers that impact full staffing capacity include increases in services provided for a growing mission, changes in state-of-the-art health care, opportunities to continue supportive partnerships with the community, changes in the size and needs of the population being served, and evolving legislative mandates.

To improve VA's ability to plan for staffing requirements, in October 2017 the Secretary established an enterprise-wide manpower management function. VA's Manpower Management Service has been actively working with the Administrations to develop standard processes to validate staffing requirements (i.e., staffing models, staffing standards, and benchmarking tools). Concurrently, each Administration established an internal manpower management functionality to meet their mission-specific needs.

VA is developing staffing models and validating staffing standards. Full manpower position management and governance over VA's organizational structure, position management, and workload-based staffing requirements is anticipated in early FY 2021. When fully implemented, manpower management processes will enable VA to more accurately define full staffing capacity requirements. These requirements will enhance VA's existing strategic human capital planning processes to ensure that workload demand is balanced by measures of quality, access, and veteran satisfaction.

VA has many long-standing clinical staffing models (e.g., specialty care, primary care, mental health,

nursing, pharmacy, and rehabilitative care) and is continuing to develop and validate other models, especially for nonclinical functional areas and positions that are Congressionally mandated (such as scribes and peer specialists per the VA MISSION Act).

Implementation of validated staffing requirements will assist in standardizing care delivery, ensuring the best care is delivered in the most efficient way possible as measured by health outcomes.

As VA's manpower management capabilities continue to expand, staffing data will become more finely tuned and will better position VA to identify and overcome staffing gaps with more fidelity.

In response to Recommendation 1 in the OIG Report, *Inadequate Governance of VA Police Program at Medical Facilities* (No. 17-01007-01), VA is currently assessing the need to centralize management of the VA Police and will determine a way ahead by the end of FY 2019. In response to Recommendation 2, VA will develop a Department-wide police staffing model by September 30, 2019. VA will update related policies and implement the model in FY 2020.

In reference to OIG 17-03347-290, *Alleged Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York*, the OIG previously closed recommendations 1, 3, 4, and 7.

Recommendations 2, 5, 8, and 9 remain open. The facility provided documentation and requested closure of recommendations 2, 5, and 8 while 9 is in progress. All Emergency Response Team calls were reviewed and analyzed by the committee and compliance was monitored. In the Community Living Center, a new rounding process was implemented as defined in the Safety Rounds standard operating procedure, and compliance was documented and monitored. Policies and practices related to Emergency Medical Responses were updated and all staff including resident physicians were trained and compliance is monitored. Education specific to Emergency Medical Responses occurred on a continual basis for rotating resident physicians.

The VISN 2 Director required continuous monitoring of the action plan for Emergency Medical Response that included document review of policies and procedures, committee minutes, post code reports, closed medical record reviews, and direct observation of unannounced comprehensive mock code drills, reported to the VISN Quality, Safety, and Value Council.

INVESTING IN WORKFORCE DEVELOPMENT

To meet VA's important mission, leaders must cultivate their workforce by providing appropriate training, giving regular and constructive performance feedback, and intervening promptly to address issues of concern. Comprehensive Healthcare Inspection Program (CHIP) reports for FYs 2018 and 2019 have raised the OIG's concerns about employee training. For example, the OIG CHIP reports for the Washington DC VAMC and the VAMC in Marion, Illinois, found that for significant numbers of staff involved in managing patients' central lines there was no evidence they received required infection prevention education. As described in later sections, changes in information technology systems and processes also require training, which has been found lacking or inadequate. For example, when VBA moved to a national work queue for processing disability claims, veterans submitting complex claims such as those related to Lou Gehrig's Disease (ALS) or military sexual trauma often lost access to specially trained processors with expertise in those areas (see Challenge 3).

VA'S PROGRAM RESPONSE

Estimated Resolution Time Frame: 2020

Responsible Agency Officials: Under Secretary for Health (USH) and Under Secretary for Benefits (USB)

In conjunction with extensive clinical skills training, VHA conducts leadership development programs focused on building the leadership competencies of health care professionals, particularly the Health Care Leadership Development Program for employees aspiring to VAMC senior leadership team positions.

In reference to OIG 18-01155048, *CHIP Review of the Marion VA Medical Center, Illinois*, the OIG closed recommendations 2-3 and recommendations 1; 4-6 remain open. The facility has completed all remaining actions and requested closure on all open recommendations in their August 2019 status update. The facility instituted a new process for tracking peer reviews for solo providers to ensure they are performed by providers with similar training and privileges; improved oversight and reporting of physical security deficiencies to ensure timely completion; improved the program for oversight and review of controlled substances awaiting destruction; and added central line-associated bloodstream infection education to New Employee Orientation to ensure all nurses are trained.

In reference to OIG 17-01757-50, *CHIP Review of the Washington, DC VA Medical Center*, the Washington, DC VAMC is committed to providing our staff the training necessary to ensure the safety of our patients and our workforce. To ensure compliance, actions included a complete review of related policies and procedures, improved systems to document staff education, and a new training process specifically targeting new hires. The staff designed and implemented a Central Line bundle of care—standardized equipment, supplies, and procedures designed to prevent infections. Evidence of compliance is presented to leadership weekly. As a result, the Medical Center realized a 57 percent reduction in central line acquired infections through the first three quarters of FY 2019 compared to the same period for FY 2018. Sustainability of this improvement is supported by a strong process for new nurse orientation, annual retraining of existing staff, and monitoring of completion. Additionally, the staff is extending this process to other hospital-acquired conditions and achieving similar results.

VBA is committed to processing all claims, regardless of complexity, as efficiently and correctly as possible. The National Work Queue (NWQ) has allowed VBA to better utilize resources nationally by distributing disability claims to regional offices (RO) with available capacity to complete the work. However, in this model, certain aspects of expertise may have been diminished—such as eliminating specialized processing teams at ROs. To combat this unintended effect, VBA reestablished specialized claims processing teams at each RO in November 2018.

These specialized teams process the most complex-type cases and are comprised of specially trained claims adjudicators with expertise in handling those claims. By reestablishing these specialized claims processing teams at every RO, VBA continues to leverage the operational efficiencies offered by the NWQ, while also developing personnel who have the appropriate specialized training and expertise to accurately process the most complex cases, such as those related to ALS, military sexual trauma, traumatic brain injury, etc. VBA has a robust training catalog through the National Training Curriculum, which ensures experienced claims processors have the means to acquire enhanced skills, take refresher training, or receive training on emerging skill requirements.

KEY RELATED LINKS

- VA 2020 Budget Request: Fast Facts; VA Office of Budget, Budget in Brief, March 2019, BiB-24.
- OIG Report: Strategic Plan: Implementation Update May 2019.
- OIG Report, Falsification of Blood Pressure Readings at the Danville Community Based Outpatient Clinic, Salem, Virginia, Report No. 18-05410- 62, January 29, 2019.
- OIG Report, Orthopedic Surgery Department and Other Concerns at the Carl T. Hayden VA Medical Center, Phoenix, Arizona, Report No. 18-02493-122, May 7, 2019.
- OIG Report, Critical Deficiencies at the Washington, DC VA Medical Center, Report No. 17-02644-130, March 7, 2018.
- OIG Congressional Testimony, "Ensuring Quality Healthcare for Our Veterans," June 20, 2019.
- GAO Report, "Managing Risks and Improving VA Health Care," High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas, GAO-19-157SP, March 6, 2019.
- OIG Report, Inadequate Governance of the VA Police Program at Medical Facilities, Report No. 17-01007-01, December 13, 2018.
- OIG Report, Alleged Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York, Report No. 17-03347-290, September 18, 2018.
- 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 Healthcare Inspection Program Review of the Washington DC VA Medical Center, Report No. 17-01757-50, January 28, 2019.
- OIG Report, Comprehensive Healthcare Inspection Program Review of the Marion VA Medical Center, Illinois, Report No. 18-01155-48, December 27, 2018.

OIG CHALLENGE 2: IMPROVING HEALTHCARE ACCESS AND QUALITY OF CARE

STRATEGIC OVERVIEW

VHA reported providing healthcare services to nearly 7 million veterans in FY 2018 through its network of more than 170 VAMCs and 1,000 outpatient sites as well as through care purchased from non-VA providers in the community. In its National Strategy for Preventing Veteran Suicide, VHA announced suicide prevention as its highest clinical priority. As part of its efforts to reduce suicide among veterans and improve mental health services, VA has focused on the Veterans Crisis Line, Suicide Prevention Coordinators, and S.A.V.E. Suicide Prevention Gatekeeper Training. These prevention efforts require engagement with community partners.

Recognizing that quality care is dependent on having supplies and equipment where and when they are needed, VA is migrating to a new inventory management system, the Defense Medical Logistics Standard Support. VA has stated it anticipates this system will help streamline supply chain management by consolidating the administration of expendable supplies and nonexpendable equipment into one system that will improve acquisition and integration issues.

Despite work in these areas, recent OIG reviews indicate that VHA continues to face obstacles in delivering quality health care to veterans, particularly as they address the challenges associated with the nationwide opioid epidemic and other behavioral health needs that significantly affect veterans.

These issues are also inextricably linked to VHA's ongoing efforts to provide timely access to care, even as there is a significant expansion of community care programs. Challenges with appointment wait times, scheduling, and consult management continue to be highlighted in OIG reviews. Deficiencies in VA hospital core services also undermine the ability of healthcare professionals to provide quality care. For example, without strong oversight to ensure VA personnel's full utilization of an effective and efficient system for medical supply and equipment management, patients may experience delays and cancellations in surgical procedures as well as with other treatments. The following three areas highlight the OIG's ongoing concerns with

- Quality of care,
- Timely access to care, and
- Effective core services.

IMPROVING QUALITY OF CARE

VHA's goal is to deliver high-quality, safe, reliable, and veteran-centered coordinated care. To meet this goal, VHA has announced that it is working to foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care while seeking continuous improvement. VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities, aspects of which the OIG routinely oversees through inspections.

VHA's Enterprise Framework for QSV includes peer reviews of clinical care, utilization management (UM) reviews, and patient safety incident reporting with related root cause analyses. Among VHA's approaches for safeguarding patients is the mandated reporting of incidents to its National Center for

Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.

During FY 2018 CHIP site visits, the OIG identified concerns with multiple QSV functions, for example, the implementation of improvement actions recommended by peer review committees. VHA requires that when peer review committees recommend individual improvement actions, clinical managers implement them. During FY 2018 CHIP site visits, the OIG inspected 386 peer reviews that identified the need for individual improvement actions and did not find evidence of action implementation in 48 of the peer reviews (12 percent). This likely prevented immediate and long-term improvements in patient care by involved healthcare providers. More information on this deficiency, as well as concerns with documentation of physician UM advisers' decisions in the national database, interdisciplinary review of that data, and provision of feedback to the employees who reported the incidents about the root cause analysis actions taken, will be reviewed in an upcoming OIG summary of 2018 CHIP reports.[3]

In addition to quality assurance difficulties, VHA experiences many challenges as it seeks to provide quality healthcare services to veterans. Among them is providing continuity of quality care when veterans access both VA and community-based healthcare and pharmacy services. The OIG has identified as a particular concern high-risk patients with chronic pain and mental illness. In its Review of *Pain Management Services in VHA Facilities*, the OIG found that of the more than 5.7 million VA patients (nonhospice/palliative care) with at least one clinical encounter during the review period, nearly 17 percent were dispensed opioids. The OIG observed that 94 percent of this population had been diagnosed with pain or mental health issues, and nearly 57 percent with both.

The OIG noted important opportunities to improve the safety of patients receiving opioid therapy and made 10 recommendations to VHA's Executive in Charge, seven of which had been implemented as of July 2019. The OIG also completed two reviews of illicit drug deaths that occurred in VA residential rehabilitation treatment programs (see Bath, New York, and VISN 10 reports in resource list). These reviews highlighted the critical importance of closely monitoring patients with both pain and mental illness, especially while those patients are undergoing intensive treatment.

As part of its ongoing oversight of VA's delivery of mental health care, the OIG remains vigilant to VA's progress on strengthening suicide prevention programs. Despite VA's considerable attention and commitment to preventing veteran suicide, the OIG continues to identify opportunities for improvement. For example, in a mid-2018 report, *Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin*, the OIG highlighte shortcomings with the root cause analysis completed after a suicide, citing superficial data collection and a conflict of interest for one of the participants conducting the review who was involved in the veteran's care. VA's ongoing work to improve the rigor of these root cause reviews is essential to gleaning important lessons that will reduce the risk of future tragedies.

Recent reports, such as *Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility*, underscore the need for consistently high-quality discharge planning from inpatient mental health treatment. The *Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities* emphasizes that all VA personnel

[3] OIG Report, Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018, Report No. 19-07040-243, October 10, 2019.

providing mental health care should have clearly defined and coordinated roles consistent with state law.

VA'S PROGRAM RESPONSE

Estimated Resolution Time Frame: 2020

Responsible Agency Official: USH

As the OIG notes, "VHA requires that its facilities operate a quality, safety, and value program to monitor the quality of patient care and performance improvement activities." It has been recognized that the central office structure does not mirror the facility and VISN structures, resulting in inconsistent oversight and support for the field.

Multiple initiatives related to modernization efforts have helped to address gaps and improve quality in VHA. Proposals for governance and VHA central office reorganization are in development to replicate programmatic and accountability structures at all levels. The proposed structures address quality and safety gaps to support improved flow of information vertically to address challenges and support organization priorities around quality and safety.

These changes allow for better promotion of evidence-based quality initiatives and allow for coordinated efforts to address and follow up on challenges identified through internal and external reviews, such as efforts to ensure facilities have an effective multidisciplinary committee to review utilization management data and efforts. Committees follow up on improvement action plans from peer review committees and root cause analysis recommendations.

In reference to OIG 16-03137-208, *Supervision and Care of a Residential Treatment Program Patient at a VISN 10 Medical Facility*, the OIG closed the recommendations on May 10, 2019. VHA made changes to internal documentation to ensure uniformity, conducted monthly treatment plan audits to ensure compliance with policy requirements, created process for review and documentation requirements for weekend programming expectations, implemented a process for program managers to review any restrictions including documentation in Computerized Patient Record System (CPRS), and conducted a 90-day medical record review to identify gaps in interdisciplinary documentation that has illustrated sustained compliance.

In reference to OIG 18-00037-154, *Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities*, all nine recommendations remain open.

The Office of Mental Health and Suicide Prevention (OMHSP) conducted national calls to VISN and facility Mental Health leadership regarding the appropriate role of Clinical Pharmacy Specialists (CPS) in interprofessional teams providing mental health care, including reference to the relevant policies that define CPS practice. OMHSP has further reviewed the process by which referrals are made to (and between) members of the mental health interprofessional team (including CPS) and shared the results broadly to maximize awareness of existing tools for managing the referral process. OMHSP has also updated national policy regarding team-based care to provide further clarity. To ensure even greater collaboration, Pharmacy Benefits Management added a representative from OMHSP to the Clinical Pharmacy Executive Board. Also, a VHA risk assessment team representing multiple offices is under development to assess potential risks related to the oversight of interprofessional mental health outpatient care teams in general.

In reference to OIG 16-03137-208, *Supervision and Care of a Residential Treatment Program Patient at a VISN 10 Medical Facility*, the OIG previously closed recommendations 1–5. The facility made

changes to internal documentation to ensure uniformity, conducted monthly treatment plan audits to ensure compliance with policy requirements, created process for review and documentation requirements for weekend programming expectations, implemented a process for program managers to review any restrictions including documentation in CPRS, and conducted a 90-day medical record review to identify gaps in interdisciplinary documentation that has illustrated sustained compliance.

In reference to OIG 18-03576-158, *Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility*, the facility fully implemented recommendations 7 and 10.

Recommendations 2 and 8 have been completed by the Mental Health Social Work supervisor. The psychosocial template was revised to include surrogate information (Recommendation 4).

Recommendation 5 has been partially completed with discharge process education having been given to the inpatient social workers. The facility is in the process of providing education to all inpatient and covering psychiatrists. The discharge process for hand-off communication has been revised (Recommendation 6) while recommendations 3 and 9 remain open. The facility has been exceeding the benchmark of 90 percent for the VA National Mental Health metric of having a mental health coordinator assigned to mental health inpatients if one has not already been assigned. A list of consultative resources for use by the inpatient mental health staff has been developed and posted on the facility's intranet site. Inpatient mental health staff were notified of these available resources via email in August 2019.

In reference to OIG 17-01823-287, *Illicit Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center*, Recommendation 1 remains open. The facility instituted a new urine drug screen tracking process and trained all domiciliary clinical staff on interpretation of urine lab results. The facility began providing in-house fentanyl screening, which reduced the turnaround time from 8.3 days to less than 2 hours and allowed for more timely and appropriate interventions to support recovery. The VISN monitored turnaround times and notification of results through the network Quality, Safety and Value Council. Domiciliary staff were provided upgrades to personal protective equipment and were trained in conducting safe and effective searches of personal belongings.

In reference to OIG 17-02643-239, *Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin*, the OIG closed all the recommendations in the report. The facility strengthened processes to ensure timely notification of county monitoring agencies in the case of court settlement violations. The facility developed a process to improve family notification in discharge planning, reviewed and revised the mental health clinical assessment process, and strengthened auditing of adherence to psychiatric medication safety prescribing guidelines. A collaborative agreement was developed to address specific conditions that require oversight of psychiatric clinical pharmacists by psychiatrists. Institutional disclosure was completed. Additional staff were interviewed for the root cause analysis.

ENHANCING ACCESS TO CARE

Despite a committed effort to improve access to care at VA facilities, and despite expanded community care and telehealth options, access continues to be a significant challenge for VHA. For more than a decade, the OIG, GAO, VA, and others have issued numerous reports regarding concerns with delays or barriers to accessing VA care. These include lengthy or inaccurately recorded veteran wait times for appointments, poor

scheduling practices, consult management backlogs, and concerns with care in the community.

Recent OIG reviews highlight the challenges associated with enhancing access through care in the community. For example, the OIG report on *Alleged Nonacceptance of VA Authorizations by Community Care Providers in Fayetteville, North Carolina*, determined that at least 15 area community care providers stopped accepting VA patients from January 2015 through July 2017 primarily because claims were not being paid in a timely manner and providers had difficulty resolving unpaid claims. At the time of the review, VA's OCC was responsible for paying non-VA care claims and the network's third-party administrator, Health Net, was responsible for paying Choice claims. The OIG determined that community providers who had stopped accepting non-VA care authorizations waited 46 days on average for their claims to be processed in 2017. The OIG also found provider frustration occurred when Health Net's clearinghouse automatically rejected some Choice claims and did not notify providers.

In addition to payment delays that compromise access to community care, recent OIG reviews have highlighted the challenges presented by the bifurcation of care between community and VA providers. In *Delays and Deficiencies in Obtaining and Documenting Mammography Services at the Atlanta VA Healthcare System*, the OIG notes serious process concerns:

- No defined process to track (1) patients whose scheduled appointments were canceled or (2) patients who may have experienced delays in care;
- Failure of a [reviewing] physician to consistently determine the clinical appropriateness of requested care [related to mammogram orders or consult submissions];
- Lack of a streamlined process for scheduling mammography imaging studies and retrieving results, and inconsistencies between facility practice and policy related to the tracking of mammography reports;
- Backlog in scanning non-VA documents into patients' VA electronic health records that may further impede clinical oversight; and
- Deficiencies in the Women Veterans Health Program, including the number of available designated women's health primary care providers and executive committee oversight.

Although four of seven OIG recommendations to address these concerns had been closed as of July 2019, significant work is still needed to strengthen care coordination between VA and community providers.

The OIG's hotline continues to see both quality of care and access to care as frequent causes for complaints and allegations of wrongdoing. Resolving timely access challenges is complicated by VA's need to implement the VA MISSION Act (including consolidating community healthcare programs into a single program that meets the needs of veterans, community providers, and VA staff) while providing uninterrupted services.

VA'S PROGRAM RESPONSE

Estimated Resolution Time Frame: 2021

Responsible Agency Official: USH

VA has invested heavily in our direct delivery system, leading to reduced wait times for care in VA facilities that currently meet or exceed the quality and timeliness of care provided by the private sector.

VA has begun to build an integrated, holistic system of care that combines the best of VA, our Federal partners, academic affiliates, and the private sector. VA improved access across its more than 1,200 facilities even as veteran participation in VA health care continued to increase. At the same time, the recently implemented Veterans Community Care Program consolidated VA's separate community care programs and put care in the hands of veterans and got them the right care at the right time from the right provider.

As part of the VA MISSION Act signed into law on June 6, 2018, VA developed access standards that meet the medical needs of veterans and support VA's goal of making sure that veterans have access to care when and where they need it. The access standards strengthen VA health care by empowering veterans with more care choices through VA medical facilities and in the community, enabling veterans to find the balance in the system that is right for them. Care and services are augmented by integrated partnerships, and community partners complement increasingly timely, high-quality care provided by VA medical facilities.

To ensure closer coordination with VA's community providers on resolution of payment issues and enable the continued expansion of VA's community care network, the OCC appointed a Provider Engagement manager, regional provider relations specialists, and national customer service specialists to work with providers on a range of issues spanning education, claims processing, and payment reconciliation.

Together, our integrated team is working with providers to create systematic and organized solutions for emergent issues they raise. VA will continue to refine its provider-focused activities to ensure better service and support to community providers, thereby addressing issues that may be compromising access to community care.

VA is also modernizing its IT systems to replace a patchwork of old technology and manual processes that slowed down the administration and delivery of community care and created issues for some of our community providers. The new IT systems will streamline all aspects of community care—from eligibility, authorizations, appointments, and care coordination through to claims and payments—all while improving overall communication between veterans, community providers, and VA staff members. For providers, implementation of the Electronic Claims Adjudication Management System will automate much of the community care referral and claims process and ensure greater quality and accuracy in claims handling while supporting timelier payments.

Finally, during FY 2019, VA developed and deployed the Provider Profile Management System (PPMS), a consolidated repository housing nationwide provider and facility information from Community Care Network (CCN) providers and providers under VA Provider Agreements. The system will expand over time to include other providers such as those working in Indian Health Service and DoD facilities. PPMS will offer provider profile information and interface to multiple VA applications to support reporting and analysis capabilities. It provides the capability to confirm provider availability and supports search functions by treating specialties and physical locations. PPMS will not be used to measure network adequacy, but rather will provide an inventory of available providers. Through its use, PPMS provides further evidence that VA is moving towards an integrated, holistic system of care that combines the best of VA, our Federal partners, academic affiliates, and the private sector.

In reference to OIG 17-05228-279, *Alleged Nonacceptance of VA Authorizations by Community Care Providers, Fayetteville, North Carolina,* Fayetteville, NC VA Coastal Healthcare System (HCS)

Community Care staff held monthly teleconference phone calls with Third-party Administrator (Tri-West) leadership and field agents, VISN 6 Business Implementation Manager, and Community Care staff from VISN 6 stations. During the monthly calls, network providers (by specialty) were discussed for Fayetteville, NC VA Coastal HCS catchment area and when deficient coverage is identified, strategies are discussed and implement to recruit additional vendors, or perform vendor recovery actions when required.

Additionally, Fayetteville, NC VA Coastal HCS Community Care staff recruited vendors for Veteran Care Agreements and CCN. These vendors were uploaded to Physician Profile Management System and the database was reviewed on a bimonthly basis to identify recruitment priorities.

In reference to OIG 17-02679-283, *Delays and Deficiencies in Obtaining and Documenting Mammography Services at the Atlanta VA Healthcare System*, the OIG previously closed recommendations 1, 5, 6, and 7. Recommendations 2, 3, and 4 remain open. The Atlanta VA HCS Director ensured that patients with mammography orders in an active, pending, or scheduled status were provided clinical care with appropriate documentation. Clinical appropriateness reviews of mammography consults were performed to ensure that the correct imaging study was ordered for the patient's clinical presentation. Providers who were trained in provision of women veterans' health care were designated as Women's Health Primary Care Providers, with the required number of women assigned to their panel, and provided gender-specific care. The facility Director provided executive level oversight of the Women Veterans Program to ensure that the coordination and streamlining of service level functions.

ENSURING THAT EFFECTIVE CORE SERVICES ARE AVAILABLE TO PROMOTE QUALITY AND TIMELINESS OF CARE

It is critical that hospitals have effective core services, including supply and equipment inventory controls, that promote quality care and patient safety in fast-paced environments. Recent oversight reviews, the most noteworthy of which was at the Washington DC VAMC, 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 these functions presents risks to patients, particularly when the lack of supplies or instruments causes surgical procedures to be canceled or delayed. In the June 2019 congressional testimony referenced earlier on enhancing quality healthcare, the OIG indicated those problems have not been fully resolved. In *Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*, the OIG reviewed this core inventory system transition and evaluated whether medical centers that participated in this migration accurately managed expendable medical supplies.

The following findings were reported:

- VAMCs encountered challenges as part of the inventory management system migration.
- Significant discrepancies existed between the Generic Inventory Package data and physical inventory counts for expendable medical supplies.
- Proper inventory monitoring and management were lacking at many VA medical centers.

While some of the issues stemmed from failure by VHA and the VISN to provide adequate oversight of the migration, OIG identified other factors that caused inventory data inaccuracies, ranging from erroneous to nonexistent inventory management practices. VA efforts are underway to address the recommendations from this review, and VA should apply the lessons learned to inform other inventory management or system migrations underway.

VA'S PROGRAM RESPONSE

Estimated Resolution Time Frame: 2019

Responsible Agency Official: USH

VHA Procurement & Logistics Office (P&LO) Policy, Training, and Assessment (PTA) conducted the first annual Quality Control Review (QCR) training on June 12, 2019 for the VISN Chief Supply Chain Officers (CSCOs). This training provided instruction on how a QCR should be conducted, tools available, and what should be reviewed during a QCR to validate compliance.

To improve QCR content, PTA stood up an Integrated Product Team (IPT) comprised of program office and field staff to review and update the current QCR checklist and scoring grid. This IPT revised these tools to reflect changes in question focus and quality, as well as a scoring grid to address deficiencies notated in the OIG report. One of the key changes to the QCR scoring tool was to add a risk matrix similar to the process used for reviews by The Joint Commission. The PTA team created a Standard Operating Procedure for an audit program in FY 2019.

In July 2019, a biweekly QCR Executive Summaries of the status of QCR action plans were submitted to VHA P&LO senior leadership. Additionally, PTA created a standing monthly action item for VISN CSCOs to track the status of the completion of facility action plans from the FY 2019 QCRs.

To mitigate instrumentation shortages at the Washington DC VAMC, the National Program Office of Sterile Processing (NPOSP) collaborated with the Washington, DC VAMC SPS to ensure the procurement and purchase of all needed instrumentation for that facility. This was accomplished by procuring a monthly contract with a third-party vendor for instrumentation to arrive at the Washington DC VAMC SPS twice monthly. This contract also provided preventative maintenance, repaired, or verified instruments as requiring replacement.

In FY 2019, upon the recommendation of NPOSP, the facility SPS created and filled additional positions to include a Reusable Medical Equipment Educator, a new SPS chief, and several SPS technicians. Prior to NPOSP's interventions in 2019, there were often many missing surgery count sheets and outdated surgery count sheets. Surgery count sheets name exactly what instruments are included for each surgery type. In 2019, 100 percent of the surgical case count sheets were updated and are complete.

NPOSP verified that instrumentation needs were met at the facility SPS by means of performing repeated site reviews, to include March 2019. Monthly calls were conducted throughout FY 2019 among facility SPS leadership, Facility leadership, and NPOSP to follow and update their Corrective Action Plan. As a result, no issue briefs have been generated due to surgical case cancellations related to instrumentation deficits.

In reference to OIG 17-02644-130, *Critical Deficiencies at the Washington DC VA Medical Center*, the facility worked diligently with support from VISN 5 to develop, revise, and update policies, SOPs and processes to ensure compliance with regulatory bodies, standards of practice, and standards of care.

The leadership reviewed and revised their governance structure and have re-engaged committees and councils that provide oversight to the departments that report to the leadership team. The facility implemented revised or new policies and SOPs to ensure that supplies, instruments, and equipment are available throughout the institution. These policies and standard operating procedures included weekly rounding by Logistics, reviews of Performance Accountability Report levels, wall-to-wall inventories, utilization of Generic Inventory Package, Prime Vendor Utilization, utilization of AEMS/MERS system,

inventory and reconciliation of the warehouse. In SPS, quality checks have been instituted including the implementation of Vensero and Censitrack, new procedures for replacing broken/missing instruments and a multidisciplinary daily OR huddle.

The facility worked diligently to provide training and education to staff on new/revised processes, policies, and SOPs, governance structure, new implemented systems/programs, privacy, records management, Temptrack, and other process changes. The institution also worked with Fiscal, Logistics, Prosthetics, and services to return clinical purchases to Logistics, improve fund controls, improve accountability of purchases, and ensure segregation of duties. Funds were made available consistently for Prosthetics to assure that services were not stopped for veterans. Regarding staffing, the leadership at the facility strived to hire and detail staff to key positions to continue providing services to veterans. Great efforts were made by the facility to improve quality, services, and accountability of assets and to comply with regulations and standards of care.

In reference to OIG 17-05246-98, *Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*, recommendations 1–6 remain open and are not expected to be fully implemented until April 2020.

KEY RELATED LINKS

- VA Office of Budget, Fiscal Year 2020 Budget Submission, March 2019, II: VHA-279.
- VA Pocket Card, VA Benefits & Health Care Utilization, April 30, 2019.
- U.S. Department of Veterans Affairs, National Strategy for Preventing Veteran Suicide: 2018–2028.
- Comprehensive Healthcare Inspection Program (CHIP) Reports.
- OIG Report, Review of Pain Management Services in Veterans Health Administration Facilities, Report No. 16-00538-282, September 17, 2018.
- OIG Report, Illicit Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center, New York, Report No. 17-01823-287, September 12, 2018.
- OIG Report, Supervision and Care of a Residential Treatment Program Patient at a Veterans Integrated Service Network 10 Medical Facility, Report No. 16-03137-208, July 12, 2018.
- OIG Report, Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin, Report No. 17-02643-239, August 1, 2018.
- OIG Report, Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility, Report No. 18-03576-158, July 2, 2019.
- OIG Report, Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities, Report No. 18- 00037-154, June 27, 2019.
- OIG Report, Alleged Nonacceptance of VA Authorizations by Community Care Providers, Fayetteville, North Carolina, Report No. 17-05228-279, September 20, 2018.
- OIG Report, Delays and Deficiencies in Obtaining and Documenting Mammography Services at the Atlanta VA Healthcare System, Report No. 17- 02679-283, September 13, 2018.

- OIG Report, Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package, Report No. 17-05246-98, May 1, 2019.
- OIG Report, Critical Deficiencies at the Washington DC VA Medical Center, Report No. 17-02644-130, March 7, 2018.

OIG CHALLENGE 3: ENSURING THE ACCURACY AND TIMELINESS OF BENEFIT SERVICES

STRATEGIC OVERVIEW

VBA delivered approximately $105 billion in federally authorized benefits and services to eligible veterans, their dependents, and survivors in 2018. Recent VBA initiatives and policy changes have been well-intentioned to expedite the benefits process but have sometimes resulted in an increased rate of inaccuracies.

OIG reports also identified other recurring deficiencies, such as poor planning and a lack of adequate controls and information technology functionality (see Challenge 6), which resulted in the inefficient delivery of services, inaccurate benefits, and an elevated risk for fraud. Further detail is provided below on the work the OIG performed on identified challenges to determine ways to

- Improve prompt and accurate benefit claims and appeals processing;
- Help VBA identify fraud, waste, and abuse within benefits services; and
- Increase the efficiency of education and other benefits administration.

IMPROVING THE ACCURACY AND TIMELINESS OF CLAIMS DECISIONS AND APPEALS

As described in the November 2018 OIG congressional testimony, "VA's Development and Implementation of Policy Initiatives," the OIG identified common systemic issues that contributed to the troubling outcomes detailed in four report findings. These include deficient control activities, inadequate program leadership and monitoring, a lack of information technology system functionality, and the unintended impacts of VBA's NWQ implementation. The work queue changes, for example, led to the discontinuance of some specialized claims processing teams. The OIG reported that about 45 percent of ALS claims completed from April through September 2017 had erroneous decisions, with estimated underpayments of about $750,000 and overpayments of about $649,000 to a total of 230 veterans. These errors reflect the complexity of these claims, which most rating personnel did not review often enough to maintain proficiency in the area. ALS claims can involve a wide range of medical complications, evaluations, and special monthly compensation levels. Similarly, within the last year, the OIG reported on related concerns regarding the adjudication of other complex claims, particularly those for military sexual trauma (MST). Discontinued specialized claims processing ultimately led to inaccurate decisions. In implementing OIG recommendations, VBA reintroduced specialized teams to complete more complex cases involving MST and ALS.

As discussed in another June 2019 congressional hearing on "Ensuring Access to Disability Benefits for Veteran Survivors of Military Sexual Trauma," the OIG made six recommendations to the USB in its 2018 report *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*. The recommendations included that VBA review all approximately 5,500 military sexual trauma-related claims denied from October 2016 through September 2017, take corrective action on those claims in which VBA staff did not follow all required steps, assign military sexual trauma-related claims to a specialized group of claims processors, and improve oversight and training on addressing these claims. The Under Secretary concurred with the recommendations and has already taken steps to address them, particularly in the area of training.

VA PROGRAM RESPONSE

Estimated Resolution Time Frame: 2020

Responsible Agency Official: USB

VBA is committed to processing all claims and appeals, regardless of complexity, as efficiently and correctly as possible. In November 2018, VBA reestablished specialized claims processing teams at each RO. This allows VBA to continue to leverage the operational efficiencies offered by the NWQ, while also developing personnel who have the appropriate specialized training and expertise to accurately process the most complex cases, such as those related to ALS, MST, traumatic brain injury, etc.

VBA is also committed to enhancing the oversight of the adjudication of claims requiring specialized processing. During FY 2019, VBA completed a review of 9,724 MST claims previously denied between October 2016 through June 2018, to certify whether appropriate actions were taken. In cases where additional actions were determined necessary, VBA is currently taking corrective action and anticipates completion by the end of FY 2019. In addition, the Quality Assurance staff in VBA's Compensation Service has a dedicated team conducting quality reviews on specific topics, which are referred to as special focus reviews. This team is conducting a special focused review of MST-related claims in the last quarter of FY 2019 to assess the quality of MST claims decisions. Any erroneous decisions found during this review will be returned to the ROs for corrective action. This review will provide findings and recommendations to identify areas for improvement through training. In FY 2019, VBA also completed a special focused review of ALS-related claims. Findings of that special review were presented to ROs during the June 2019 monthly national Quality Assurance call. VBA also drafted technical business requirements to enhance system functionality that will generate language in ALS-related notification letters informing veterans of any additional special monthly benefits to which they may be entitled because of their ALS disability.

VBA also remains committed to enhancing the oversight of its appeals program and improving the quality and processing timeliness of its appeals decisions. VA successfully implemented the Veterans Appeals Improvement and Modernization Act of 2017 (AMA) on February 19, 2019, which streamlines the disagreement process and establishes three decision review options: higher-level review, supplemental claim, or appeal to the Board of Veterans' Appeals (Board). This is one of the most significant statutory changes to affect VA in decades. VBA's Decision Review Operations Centers (DROC) have processed the intake of over 80,776 AMA claims since February 19, 2019. DROCs are processing higher-level reviews and other AMA-related claims in 33.3 days, well below the 125-day timeliness goal. VBA's Appeal Management Office, which is responsible for the oversight of VBA's appeals, is also committed to eliminating its nonremand legacy appeals, which it expects to resolve in FY 2020. By end of July 2019, VBA had less than 152,000 in its nonremand legacy inventory (compensation and pension appeals). Furthermore, VBA is leveraging feedback from the higher-level reviews and Board remands to improve claims decision accuracy.

IDENTIFYING AND MITIGATING THE RISK OF BENEFITS-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. VA's ongoing "Seek to Prevent Fraud, Waste and Abuse" (STOP FWA) initiative is expected to ensure a more consistent approach throughout VA to curtail misconduct. Nonetheless, the OIG continues to identify areas of

concern. For example, in *Timeliness of Final Competency Determinations*, the OIG identified delays in completing final competency determinations, resulting in potentially incompetent beneficiaries receiving ongoing benefits payments for extended periods without the protection of a VA-appointed fiduciary.

Further, during the first half of FY 2019, the OIG opened 108 investigations involving the fraudulent receipt of VA monetary benefits, including those for deceased payees, fiduciary fraud, identity theft, and fraud by beneficiaries, which resulted in 39 arrests. The OIG also obtained more than $8.5 million in court-ordered fines, restitution, penalties, and civil judgments; achieved more than $33.4 million in savings, efficiencies, and cost avoidance; and recovered more than $5.9 million.

VA PROGRAM RESPONSE

Estimated Resolution Time Frame: 2020

Responsible Agency Official: USB

Utilizing contract support, VBA created algorithmic programs to proactively identify fraudulent direct deposit changes, improper benefits payments in VA's Disability Compensation and Pension programs, as well as assisting State and Federal investigative agencies with evidence collection. During FY 2019, VBA completed the initial analysis that identified approximately $181 million in potential improper payments as a result of deceased veterans, beneficiaries, and dependents not originally caught in the Social Security Administration (SSA) Death Master file match. In August 2019, VBA expanded its information sharing agreement with SSA to include information regarding deceased dependents of VA Disability Compensation and Pension benefit recipients. This expansion strengthened the current data exchange with SSA that notifies VBA of a primary beneficiary's death. The new data sharing agreement promotes more timely adjustments of VA's monthly monetary benefits, reduces improper payments, and decreases potential overpayments. By increasing the scope of Federal matching programs, VBA can streamline and improve the accuracy of benefit calculating by relying less on self-reported claimant information.

VBA continues to utilize proactive algorithms that identified over 70 percent of all fraudulent direct deposit changes before the veteran or VA beneficiary knew they were victims of fraud. As of August 1, 2019, the algorithms had identified over 3,300 fraud cases, and allowed VBA to prevent or recover over $4.29 million from being stolen from veterans and the VA. VBA has provided the OIG full access to the evidence and analyses for the 3,300 fraud cases. To better serve veterans who were victims of fraud, VBA scripted automated investigation determinations and revamped the process to ultimately reduce veteran victim repayment times from over 28 days to less than 6 business days.

In efforts to further assist the OIG, VBA's analytics team continues to build out connected case and trend analysis investigation models to graphically show active fraud rings as well as provide both raw and aggregated data to investigators. In addition to proactively identifying payment redirect fraud, VBA continues to develop algorithms to identify fraudulent benefits double-dipping schemes as well as improper payments due to people, process, and system errors. Over the past two years, VBA identified and remediated over 70 veterans who were being double paid as a result of duplicate corporate records. VBA also sent six additional proactive fraud investigation requests to the OIG.

VBA is currently overhauling its fiduciary field examination process and implementing new technology allowing the agency to increase efficiencies, better utilize valuable resources, and strengthen oversight of the fiduciary program. In April 2019, VBA implemented overarching procedural changes to its fiduciary

accounting and misuse process to improve identification of misuse when an accounting is delinquent, erroneous, or incomplete. Three months later, VBA revised its procedural guidance reducing process delays for final incompetency determinations when VA beneficiaries submit additional evidence.

Together, these process improvements and technology advancements allow VBA to reduce fraud, waste, and abuse in VA benefit programs.

EFFECTIVELY AND EFFICIENTLY ADMINISTERING EDUCATION AND OTHER BENEFITS

Recent hearings and media accounts have focused attention on concerns that eligible veterans are not receiving their benefits promptly, particularly those related to education. There are concerns about VA overpayments related to benefits as well.

OIG reports and congressional testimony (see resource list below) highlight significant financial risks related to how education benefits—including those under the Post-9/11 Veterans Educational Assistance Act of 2008 (Post-9/11 GI Bill) and the Forever GI Bill—are administered.

In V*A's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students*, the OIG estimates that 86 percent of state approving agencies did not adequately oversee veterans' education and training programs to make certain that only eligible programs participated. The OIG estimated that, without correction, VBA could issue an estimated $2.3 billion in improper payments to ineligible programs over the next five years.

VBA also faces challenges in efficiently administering benefits under the Survivors' and Dependents' Educational Assistance Program, the VA's second-largest education program. For example, the OIG found in *Delays in the Processing of Survivors' and Dependents' Educational Assistance Program Benefits Led to Duplicate Payments* that delays in processing program benefit adjustments also led to overpayments totaling approximately $4.5 million through February 1, 2018. The causes of those delays include the lack of management of the electronic mailboxes at the regional and national levels, an ineffective notification process, and the lack of system functionality to flag cases with duplication of benefits. In addition, some workload distribution rules caused cases not to be distributed when ready for processing. Continued delays could result in an estimated $22.5 million in improper payments over a five-year period.

As an example of challenges encountered outside the education arena, the OIG report on *Exempt Veterans Charged VA Home Loan Funding Fees* found that about 72,900 veterans were charged about $286.4 million in funding fees between 2012 and 2017 despite those veterans being exempt from such fees because they were entitled to receive VA disability compensation.

Also, VBA's Loan Guaranty Service managers that oversee VA's home loan guaranty program were aware since October 2014 that thousands of exempt veterans may have been charged home loan funding fees. The team estimated VA had not yet given about $189 million in funding fee refunds to about 53,200 exempt veterans. VA has taken steps to address this problem.

VA PROGRAM RESPONSE

Estimated Resolution Time Frame: 2020

Responsible Agency Official: USB

In February 2019, VA awarded a software development and systems integration contract to Accenture Federal Services to make the necessary IT changes and updates to support the processing of education benefits under the Post-9/11 Veterans Educational Assistance Act of 2008 (Post-9/11 GI Bill) and the Harry W. Colmery Veterans Educational Assistance Act (Forever GI Bill). The Forever GI Bill is one of the most significant statutory changes to affect the Post-9/11 GI Bill benefit program since its inception. Since its passage, VA implemented 26 GI Bill-related provisions from the Colmery Act and is on-track to deploy the IT solution on December 1, 2019, for sections 107 and 501 of the Colmery Act.

VBA negotiated an amendment to the FY 2020 State Approving Agencies (SAA) cooperative agreement that requires SAAs to evaluate program and operational changes that may affect a program's continued eligibility, at a minimum once every 24 months, beginning October 1, 2019. Furthermore, VBA established a work group to strengthen program oversight by developing a system of controls to ensure education and training programs comply with Title 38 requirements, protect taxpayers' and students' interests, and reset quality assurance metrics for the approval process and annual compliance surveys. Lastly, VBA contracted with WP Cioffi for a recalibration of the SAA funding allocation model. Once the allocation model has been finalized, VBA will determine if adjustments to the funding distribution among the SAAs are warranted and if the total amount available for SAA contracts in the statute is adequate.

VBA's Compensation Service and Education Service collaborated to identify cases with potential duplication of compensation and Dependents' Educational Assistance benefits and create an email portal directly notifying the veterans service centers. VBA submitted IT business requirements for system functionality that will flag cases with duplication of benefits with a claim identifier, establish a system work item, and create a recurring report. The NWQ began assigning cases with the claim identifier for compensation award adjustments to remove the school child allowance and minimize any duplication of benefits and overpayment of benefits to veterans.

VA recognizes the importance of ensuring our nation's veterans are assessed fees and charges in accordance with VA policy, statutes, and regulations. VBA began processing home loan funding fee refunds on approximately 130,000 loans at all eight of its VA regional loan centers on July 1, 2019, and expects to complete the work no later than September 30, 2019. Going forward, refunds will be processed monthly for all veterans who receive a retroactive VA disability rating during the previous month and any exempt veterans who were charged in error by lenders on loans that were guaranteed during the previous month. Historically, VA tasked lenders with verifying the "exempt" status of veteran home buyers and the Department would identify waiver cases using its own internal loan audit process or by relying on veterans contacting VA directly.

Certificates of Eligibility (COE) include the veteran's current funding fee exemption status. Information about funding fee refunds is also included on the COE to fully inform nonexempt veterans who may later receive a retroactive rating. Information about funding fee refunds is also provided in disability compensation award letters.

VA also modified the "home loan welcome" letter to make sure veterans know they may qualify for a

loan fee waiver, should they later obtain a VA disability compensation award. Lenders are now required to ask veterans and servicemembers if they have a disability claim pending with VA, and if so, to update the funding fee exemption status within three days of closing. Additional information about funding fee refunds has been added to the nationwide phone system menu. This menu prompt offers a detailed recorded message about funding fees, followed by the option to speak with a Loan Specialist.

KEY RELATED LINKS

- VA Office of Budget, Budget in Brief, March 2019, BiB-24.
- OIG Congressional Testimony, "VA's Development and Implementation of Policy Initiatives," November 29, 2018.
- OIG Report, Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis, Report No. 18-00031-05, November 20, 2018.
- OIG Congressional Testimony, "Ensuring Access to Disability Benefits for Veteran Survivors of Military Sexual Trauma," June 20, 2019.
- OIG Report, Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma, Report No. 17- 05248-241, August 21, 2018.
- OIG Report, Timeliness of Final Competency Determinations, Report No. 17-05535-292, September 28, 2018.
- OIG Congressional Testimony, "Examining Ongoing Forever GI Bill Implementation Efforts," May 9, 2019.
- OIG, Semiannual Report to Congress, Issue 81, October 1, 2018–March 31, 2019: 27.
- OIG Issue Statement, Forever GI Bill: Early Implementation Challenges, Report No. 19-06452-97, March 20, 2019.
- OIG Report, VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students, Report No. 16-00862-179, December 3, 2018.
- OIG Report, Delays in the Processing of Survivors' and Dependents' Educational Assistance Program Benefits Led to Duplicate Payments, Report No. 18- 01278-13, December 18, 2018.
- OIG Report, Exempt Veterans Charged VA Home Loan Funding Fees, Report No.18-03250-130, June 6, 2019.

OIG CHALLENGE 4: ENHANCING FINANCIAL MANAGEMENT AND CONTROLS

STRATEGIC OVERVIEW

Sound financial management is integral not only to ensuring the best use of limited public resources, but also to collecting, analyzing, and reporting reliable data to inform resource allocations. To that end, addressing shortcomings in VA's financial management would improve stewardship of the public resources entrusted to VA's use. Each year, the OIG audits VA's consolidated financial statements, as required under the Chief Financial Officers Act, and completes a mandatory review of VA's compliance with the Improper Payments Elimination and Recovery Act (IPERA). The OIG also reviews other programs and activities to assess VA's management of appropriated funds.

During these reviews, VA's financial management system has routinely been identified as a contributing factor to internal control weaknesses. VA's system is over 25 years old and has limited functionality to meet current financial management and reporting needs. To address this, VA's Financial Management Business Transformation (FMBT) program is focused on migrating VA to a financial and acquisition management system solution that is compliant with federal requirements. VA reports the FMBT program will increase the transparency, accuracy, timeliness, and reliability of financial information across VA, resulting in improved fiscal accountability to taxpayers and increased opportunity to improve care and services to veterans.

While the migration to a new system should help facilitate improvement in some areas, the OIG has concerns with VA's persistent struggle to adhere to IPERA requirements and the consequent increase in improper payments through noncompliant programs and activities. Specific issues identified during the OIG's work this year relate to

- Financial controls,
- Improper payment rates, and
- VA's ability to manage appropriated funds.

IMPROVING FINANCIAL CONTROLS

The audits of VA's financial statements for FYs 2017 and 2018 identify five material weaknesses, which represent a deficiency or combination of deficiencies in internal controls 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.

The five material weaknesses identified are

1. Community care obligations, reconciliations, and accrued expenses;
2. Financial systems and reporting;
3. IT security controls;
4. Compensation, pension, burial, and education actuarial estimates; and
5. Entity controls, including those pertaining to the organizational structure of financial management and Chief Financial Officers.

The report also notes significant deficiencies regarding loan guarantee liability and procurement, undelivered orders, accrued expenses, and reconciliations. Four of the five material weakness were found in the prior year's audit. There were also two significant deficiencies. Because some of these deficiencies were due in part to limitations in VA's financial and acquisition systems, complete resolution will only be possible upon the successful completion of the FMBT program. VA expects this transformation to yield a modern financial and acquisition management solution with standardized business processes and reporting capabilities.

System shortcomings were also behind noncompliance with the Federal Financial Management Improvement Act (FFMIA). VA was noncompliant with federal financial management systems requirements and the United States Standard General Ledger at the transaction level under FFMIA. VA reported one violation of the Antideficiency Act in September 2018 and at this writing is in the process of reporting a second violation identified in FY 2018. In addition, VA identified five other violations of the Antideficiency Act that are carried forward from prior years and are under further discussion with the OMB's Office of General Counsel, as well as noncompliance with IPERA for FY 2017, the basis for which was previously reported by the OIG since 2012.

VA'S PROGRAM RESPONSE

Estimated Resolution Time Frame: Ongoing

Responsible Agency Officials: Office of Management, OIT; Administrations

VA is committed to resolving the five material weaknesses and has been making incremental improvements to mitigate them. To address the significant challenge of replacing antiquated systems, which is the main cause for many of these weaknesses, VA embarked on a major systems improvement initiative to modernize the financial and acquisition systems. This effort will increase the transparency, accuracy, timeliness, and reliability of financial information, resulting in improved financial controls and fiscal accountability to American taxpayers.

In addition, VA is taking targeted actions to address the material weaknesses pertaining to the benefits program actuarial liabilities. Specifically, VA hired two additional certified actuaries in FY 2019 to address the material weaknesses related to establishing benefits program liabilities.

VA implemented a new Obligate at Payment process in FY 2019 for Community Care. This process allows us to obligate at the time of payment, thus reducing our stale obligation population. Furthermore, VA hired a Chief Actuary to develop and support an actuarial model to determine the liability for Community Care's incurred but not reported transactions.

To address the material weakness around financial reporting, VA continues to use a standardized approach for performing quarterly financial statement variance analysis and monthly abnormal balance reviews. This helps to identify 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. VA has also developed procedures and controls to continually decrease the number of manual journal vouchers. VA continues to perform monthly analysis to further decrease the variances between budgetary to proprietary tie points.

In response to Entity controls, including those pertaining to the organizational structure of financial management and Chief Financial Officers, VA's CFO established a formal CFO council to facilitate communication and control over Departmentwide CFO functions and is using the council meetings

to discuss remediation activity for the Financial Statement audit. The Administrations and program offices are actively engaged and continuously working to improve and strengthen controls in financial management.

REDUCING IMPROPER PAYMENT RATES

VA continues to struggle to comply with the requirements of IPERA, as evidenced by a significant increase in improper payments in FY 2018. In the 2018 Agency Financial Report, VA discloses improper payments totaling $14.73 billion, an approximately 38 percent increase from the $10.66 billion reported in FY 2017. This increase was primarily due to VA identifying and reporting higher improper payments for eight programs and activities—seven in VHA and one in VBA. Several programs and activities were identified as noncompliant for several consecutive years—four for four years, one for three years, and four for two years.

With the implementation of the VA MISSION Act, which carries the risk of significant cost overruns, it is imperative that VA continue to address the root causes of improper payments for community care identified during OIG audits. For example, the 2018 OIG report on *Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts* raised major concerns about how VA processed aggregate payments (referred to as "bulk payments"). The OIG determined that third-party administrators submitted requests for, and VA made, 253,641 duplicate payments on 4,758,759 claims (5.3 percent) through the bulk payment process from March 4, 2016, through March 31, 2017. Due to ineffective internal controls, VA failed to identify improper claims submitted by third-party administrators and made a total of $101.4 million in estimated overpayments to them. Other payment errors occurred because VA did not effectively follow internal control principles identified in the GAO's *Standards for Internal Control in the Federal Government*. VA is currently working to ensure proper processes are in place to prevent payment of duplicate claims. VA is also reviewing and determining an appropriate process to recoup the identified overpayments.

In another example, the OIG's report on *Use of Not Otherwise Classified Codes for Prosthetic Limb Components* revealed that from October 2014 through July 2017, VHA spent approximately $38 million on prosthetic items classified using a not-otherwise-classified code, overpaying vendors about $7.7 million. Using an incorrect code can cause an overpayment because items not otherwise classified are not subject to established reimbursement rates.

VA PROGRAM RESPONSE

Estimated Resolution Time Frame: 2022

Responsible Agency Officials: Assistant Secretary for Management and CFO (Lead); Executive in Charge VHA; USB; and Principal Executive Director and Chief Acquisition Officer Office of Acquisition, Logistics, and Construction

VA did report approximately $14.73 billion in improper payments in its FY 2018 Agency Financial Report, which is an increase over prior years. As also noted in the AFR, most of these improper payments (87.3 percent) did not represent a loss or waste. VA fully understands the risk of loss in its programs and is committed to implementing changes that will prevent this going forward. However, because the definition of improper payments also includes administrative errors such as failure to follow a requirement that did not result in loss, VA cannot focus on only those payments that result in a loss. VA has worked diligently to understand the root causes that are causing its improper payments and develop

realistic plans and timelines for implementing corrective actions, which will increase compliance. All programs with an improper payment rate above 10 percent have a corrective action plan in place to reduce the improper payment rate to under 10 percent within three years. While those corrective actions are being worked daily, many address systemic issues that will take time to implement (such as VA MISSION Act and awarding contracts in other programs).

This means that VA will not fully report the results of all ongoing and planned corrective actions until the FY 2022 Agency Financial Report. However, as corrective actions are successfully implemented during this time frame, VA will report reductions. We remain committed to reducing improper payments, especially monetary loss, while still ensuring that our actions do not impact timely access to care.

IMPROVING MANAGEMENT OF APPROPRIATED FUNDS

Federal agencies are expected to abide by the body of law that governs how appropriated funds may be used, adhering to the golden rules of fiscal law: purpose, time, and amount.[4] However, OIG reviews reveal that VA has struggled in this regard. One example from a recent OIG report on *Decision Ready Claims Program Hindered by Ineffective Planning* related to improper payments for medical exams to support veterans' applications or claims for disability compensation. VBA contravened federal statutes and regulations by obligating and expending more than $10.5 million for contract medical examinations before veterans applied for disability compensation benefits. Because no claim had been made at the time of the medical examination, there was no entitlement to such examination under federal law, and no appropriated funds were available to pay for it. Accordingly, any such obligation and expenditure would violate the Antideficiency Act, in addition to potentially being an improper payment.

VA again appeared to have difficulty in cost-effectively implementing a major initiative. In *Lost Opportunities for Efficiencies and Savings During Data Center Consolidation*, detailing VA's approach to migrating IT server infrastructure to data centers, the OIG found that VA did not maintain complete, up-to-date data center inventories. VA also lacked an adequate plan to meet optimization targets for data centers at its existing facilities. Consequently, VA lost opportunities to consolidate data centers, which would increase its operational efficiency and achieve additional cost savings. Furthermore, VA did not satisfy the data center consolidation strategy provisions of the Federal IT Acquisition Reform Act. VA also did not meet the OMB's FY 2018 target of $85.35 million in planned savings and cost avoidances. VA has efforts underway to effectively communicate OMB's Data Center Optimization Initiative requirements to all staff responsible for its data centers. In addition, VA is developing a mechanism for validating the accuracy and completeness of reported data center information to the OIT's National Data Center Program team.

VA'S PROGRAM RESPONSE

Estimated Resolution Time Frame: Resolved

Responsible Agency Officials: USB and the Assistant Secretary for OIT and Chief Information Officer (CIO)

This challenge is covered by two VA organizations: VBA and OIT. The organizations have responded specifically to those parts of the challenge that pertain to them.

[4] Purpose ("necessary expense rule") is using the appropriated funds specifically for the purpose intended by Congress. Time ("bona fide needs rule") is obligating the appropriated amount within the allowed time for each specific type of funding. Amount (Antideficiency Act) prohibits obligations and expenditures in advance or in excess of an appropriation. See GAO, *Principles of Federal Appropriations Law*, 2016 rev., ch. 2, § C.1, GAO-16-464SP (Washington, DC: March 2016).

VBA'S Response

VBA's Decision Ready Claims (DRC) program ended on February 19, 2019, and no additional medical disability examinations were requested under that program after that date. VBA disagreed with the OIG's interpretation of the Antideficiency Act, citing detailed interpretation of VA appropriation statutes as well as legal precedent. Given that the expenses for DRC examinations allowed VBA to carry out its general function of providing examinations for claimants, it is VBA's position that expenses related to these examinations constitute an appropriated or necessary expenditure. Additionally, of the $10.5 million cited by the OIG as improper payments made under the DRC program, only $972,000 (9.3 percent) was actually expended.

OIT's Response

Regarding OIG's report, *Lost Opportunities for Efficiencies and Savings During Data Center Consolidation* (Report No. 16-04396-44), since the audit took place in 2016, the OIT developed an accurate mechanism for validating the accuracy and completeness of reported data center information to the OMB. The OMB closure target was arbitrarily set up and did not take agencies' missions into consideration. To meet the OMB closure target, VA would have been required to close mission-critical data centers providing health care services to veterans. VA and OMB worked together to establish an informal target of 60 data center closures in FY 2018, which VA exceeded by closing 78.

The Data Center Optimization Initiative (DCOI) strategic plan for FY 2017 and FY 2018 did not include cost savings targets since VA was not closing brick and mortar data centers but moving servers from communications closets to computer rooms. The reasoning behind the lack of cost savings/avoidances was also communicated to OMB. The realized cost avoidance VA reported was based on utilizing two Federally shared data centers in lieu of using a commercial lease when consolidating VistA.

The updated DCOI memo, published on June 25, 2019, provides updated DCOI metrics for FY 2019 and FY 2020. These now include: Energy Metering, Virtualization, Server Utilization, and Availability.

The OIG closed all recommendations for the cited report, *Lost Opportunities for Efficiencies and Savings During Data Center Consolidation* (Report No. 16-04396-44) – effective July 1, 2019.

KEY RELATED LINKS

- OIG Report, Audit of VA's Financial Statements for Fiscal Years 2018 and 2017, Report No. 18-01642-09, November 26, 2018.
- OIG Report, VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2018, Report No. 18-05864-127, June 3, 2019.
- OIG Report, Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts, Report No. 17-02713-231, September 6, 2018.
- OIG Report, Use of Not Otherwise Classified Codes for Prosthetic Limb Components, Report No. 16-01913-223, August 27, 2018.
- OIG Report, Decision Ready Claims Program Hindered by Ineffective Planning, Report No. 18-05130-105, May 21, 2019.
- OIG Report, Lost Opportunities for Efficiencies and Savings During Data Center Consolidation, Report No. 16-04396-44, January 30, 2019.

OIG CHALLENGE 5: OVERSEEING THE COMPLIANCE AND INTEGRITY OF PROCUREMENT PRACTICES

STRATEGIC OVERVIEW

VA procures tremendous quantities of goods and services from vendors through contracts and purchase card transactions to facilitate departmental operations and deliver medical care and benefits to veterans. To provide oversight of that effort, in FY 2018, the OIG assessed procurement practices through preaward and postaward contract reviews, program reviews, and investigations. Recent OIG reviews noted ongoing opportunities to strengthen VA's procurement practices.

The improvements recommended to correct these deficiencies will decrease the risk of continued waste. As discussed below,

- The OIG uncovered significant discrepancies between VA contracting practices and requirements, as well as vendor noncompliance; and
- VA continued to experience potential illegal or improper purchasing due to an overall failure to identify and detect improper purchase card practices.

Without improvements, VA faces challenges to ensuring that goods and services are acquired properly and promptly.

IMPROVING CONTRACTING PRACTICES

VA continues to struggle to maximize opportunities for contract-related cost savings and recoveries, which the OIG identifies through preaward and postaward contract reviews as well as audits. In the first six months of FY 2019 alone, through 35 preaward reviews,[5] the OIG identified nearly $1.3 billion in potential cost savings that could be negotiated by VA. During the same period, through postaward contract reviews, some of VA's vendors were found to be noncompliant with contracts or specific terms. The OIG completed 18 postaward reviews that resulted in $22 million in recoveries of contract overcharges, including approximately $8.6 million related to the Veterans Health Care Act compliance with pricing requirements, recalculation of federal ceiling prices, and appropriate classification of pharmaceutical products.

The OIG also recently published an audit of *VA's Administration of the Transformation Twenty-One Total Technology Next Generation Contract*, which involves awards to 28 contractors for IT services with a total maximum value of $22.3 billion. While the OIG did not identify violations of federal and VA acquisition regulations (VAAR), the audit team found oversight weaknesses that, if not corrected, could increase the likelihood of VA conducting business with contractors unable to provide services according to contract requirements. These weaknesses place IT systems and hundreds of millions of taxpayer dollars at risk and potentially harm VA's ability to fulfill its mission to care for veterans.

[5] In May 2018, VA revised its Directive 1663 that requires CORs to submit sole-source proposals for healthcare resources valued at $400,000 or more annually to the OIG for a preaward review.

VA'S PROGRAM RESPONSE

Estimated Resolution Time Frame: Ongoing

Responsible Agency Official: Principal Executive Director of Office of Acquisition, Logistics, and Construction

The Office of Acquisition, Logistics, and Construction has an established procedure for pre- and postaward reviews for the Federal Supply Schedule (FSS) Program, which are currently performed by the OIG. Preaward and postaward reviews are performed when an offer or contract meets the established dollar threshold, when irregularities are found, or as required by P.L. 102-585, Veterans Health Care Act of 1992 (pertains to covered drugs). Once the review is complete, the FSS contracting staff considers and uses the OIG recommendations when negotiating contract pricing and determining an award. With postaward reviews, VA negotiates a settlement to recover any overcharges. This practice has been in place for over 39 years and will continue as long as the VA FSS program is viable.

Although the OIG's audit of *VA's Administration of the Transformation Twenty-One Total Technology Next Generation Contract* identified what they consider oversight weaknesses despite no violations of Federal or VAAR, VA's Chief Acquisition Officer and Senior Procurement Executive agreed to present the OIG's recommendations for additional policy to the Department's Senior Procurement Council to review and assess full consideration, impacts, and implied benefits of additional policy, and to establish standards for internal controls within VA at an enterprise level, rather than imposing additional requirements just for Technology Acquisition Center (TAC) contracting staff. This enterprise approach is further supported by the most recent GAO report that concludes VA's regulations and policies are both outdated and disjointed, calling them difficult for contracting officers to use. The OIG's recommendations that indicate TAC alone should put policies in place, as identified in their report, would serve to further exacerbate the very problem identified by the GAO as it relates to disjointed Departmental policy.

IMPROVING PURCHASE CARD PRACTICES

VA's Financial Services Center (FSC) Data Analytics team has developed an interactive analytics dashboard with a comprehensive view of VHA purchase card behavior. This data is generated by the FSC using data obtained directly from US Bank with supporting detail. The dashboard was started in 2018 to help the FSC flag potential purchase card issues. VA reports it is being rolled out in 2019 and will be available for purchase card managers to help them monitor purchase card behavior in their facility. The dashboard is meant to provide an improved level of transparency over purchase card use and includes analytical tools for reviewers to drill down to the transaction level for details on purchases such as those from high-risk vendors, transactions over the purchase cardholder's limit, and potential split purchases.

Despite efforts to improve monitoring, the OIG continues to see instances in which VA personnel are inappropriately using purchase cards to circumvent the contracting process and otherwise misusing purchase cards, which can undercut VA goals and invite fraud and abuse. This is particularly the case when the same employees are both ordering and receiving goods or services, leaving these activities largely unchecked. VA continues to face barriers to ensure that purchase cardholders acquire goods and services properly and in a timely manner when there is a bona fide need. In one example, an OIG fraud investigation resulted in charges that the defendants used a VA purchase card to pay fraudulent invoices. A former VA supervisor and his wife provided a third-party vendor with fraudulent invoices from her company for goods and services that were not actually provided to the vendor. The vendor then fabricated his own set of fraudulent invoices to bill VA for goods and services. The amount of the

invoices billed to VA and paid for with the VA purchase card equaled the amount the vendor paid the wife's company plus a 30 percent commission. The loss to VA is at least $714,000.

Another example illustrates how lax oversight of purchase card transactions can affect veterans. After receiving an OIG hotline allegation that a veteran had waited over six months for prosthetics ordered and paid for by VA, the OIG requested a response from the VAMC in San Antonio, Texas. The medical center determined that the purchasing agent failed to follow up with the vendor to ensure that the required order had been received. As a result of this case inquiry, the purchasing agent received appropriate counseling, new cross-checks between purchase card transactions and receipts were implemented, and a supervisory purchasing agent was hired. The OIG subsequently closed the matter.

In the report on the *FY 2018 Risk Assessment of VA's Charge Card Program*, the OIG found that VA's overall capacity to detect illegal, improper, or erroneous purchases is unchanged from the prior year.

VA'S PROGRAM RESPONSE

Estimated Resolution Time Frame: 2021

Responsible Agency Official: OM

VA manages one of the largest purchase card programs in the Federal government. In FY 2018, VA spent $4.6 billion on over 7.1 million transactions. Such high volume of transactions increases the risks of fraud and errors. Understanding this risk, VA has made concerted efforts to improve the program controls over the past 10 years.

Among the internal controls VA has implemented are reducing the number of purchase card accounts and restricting high-risk merchant category codes, e.g., sporting goods. In addition, VA performs quarterly statistical audits of charge card purchases to ensure cardholders and approving officials reconcile their transactions timely to verify that purchases are proper. VA confirms that all purchase card transactions over the micro purchase threshold are made by warranted contracting officers. Furthermore, VA Financial Policy requires ongoing training for all purchase cardholders every two years. In addition to the internal controls implemented and as noted by the OIG, VA FSC developed an interactive analytics dashboard with a comprehensive view of VA purchase card transactions. The FSC recently added a Compliance Audit Division (CAD) to assist in reviewing card activities and to identify and reduce risk. Furthermore, the CAD will conduct random site inspections to verify inventories and receipt of the required orders.

There is no internal controls system that can stop all instances of fraudulent activities involving collusion. However, VA is committed to improving internal controls by making appropriate changes to Financial Policy as potential weaknesses are identified. The key oversight goal of VA's purchase card program remains reducing and eliminating the risk of fraud. VA will continue to refine and improve its purchase card program and associated purchase card practices and oversight.

KEY RELATED LINKS

- OIG Semiannual Report to Congress, Issue 81, October 1, 2018–March 31, 2019: 25 and 40.
- OIG Report, VA's Administration of the Transformation Twenty-One Total Technology Next Generation Contract, Report No. 17-04178-46, June 13, 2019.
- OIG Report, Fiscal Year 2018 Risk Assessment of VA's Charge Card Program, Report No. 19-00223-166, July 22, 2019.

OIG CHALLENGE 6: MINIMIZING RISKS AND INCREASING EFFECTIVENESS FOR INFORMATION MANAGEMENT SYSTEMS

STRATEGIC OVERVIEW

Secure and well-integrated IT systems and networks are integral to VA mission-critical programs and operations. VA has taken steps to advance its security efforts, demonstrated by the continued implementation of VA's ECSP initiative.

The related strategic plan is designed to help VA achieve transparency and accountability while securing veterans' information. The ECSP team has launched 31 plans of action to address previously identified security and IT weaknesses.

However, since 2000, the OIG has identified information management as a major management challenge. VA's problems with planning and implementing IT affect the healthcare and benefits systems serving millions of veterans, their family members, and caregivers. The contributing causes include lack of leadership, decentralized governance in which roles and responsibilities are unclear, failures to adequately plan and test technology to ensure it meets VA personnel and other users' needs, and improper use or reliance on ill-suited software. These persistent issues are also concerning given the magnitude of VA's IT investments. For example, for FY 2020, VA has requested $4.3 billion to fund information system security, system development initiatives, and system operations and maintenance.

Systems changes, such as the one proposed for electronic health records (EHR) alone, can have a staggering impact on healthcare providers' ability to make informed decisions for their patients, as well as veterans' ability to access their comprehensive records and to keep that information private. To replace VistA, VA's legacy EHR system, with a commercially available software product, VA contracted with Cerner to provide the Millennium EHR, the same system that the DoD is deploying globally to replace its legacy EHR systems. Given the tremendous size, scope, and complexity of the EHR replacement, VA will take approximately 10 years to deploy the system nationally. When factoring in program management and infrastructure improvements, the program could cost upwards of $16 billion. Replacing the IT system for use by these two massive, interconnected healthcare information systems requires robust, consistent leadership, as well as individual and joint management structures. Additionally, VA must address the cultural and work process changes that the new system brings, requiring the training of hundreds of thousands of healthcare providers and workers. As VA's first go-live event in March 2020 approaches, there are still countless governance and planning decisions to be made to minimize the disruption caused by a transition of this scale. The OIG has been monitoring VA's progress on this effort to ensure it is positioned to provide oversight and accountability.

As described below, in FY 2019, the OIG completed audits and programs that recommend improvements to VA on

- Ensuring appropriate information technology safeguards are in place, and
- Reducing the risks to patients and poor outcomes for other beneficiaries of VA programs when new or changed IT and related processes are carried out.

ENSURING EFFECTIVE INFORMATION SECURITY PROGRAM AND SYSTEM SECURITY CONTROLS

During an April 2019 hearing before the Subcommittee on Technology Modernization of the House Committee on Veterans' Affairs, the OIG summarized audits that demonstrated IT systems development is a persistent challenge for VA. Its information security program and practices are the cornerstone to VA's ability to provide benefits and services to veterans in a manner that protects the confidentiality, integrity, and availability of VA systems and data. 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. As reflected in OIG's *FISMA Audit for Fiscal Year 2018*, VA continues to face significant challenges in complying with the requirements of FISMA due to the nature and maturity of its information security program. To achieve better FISMA outcomes, VA needs to take actions that

- Address security-related issues that contributed to the IT material weakness reported in the FY 2018 audit of VA's consolidated financial statements;
- Improve deployment of security patches, system upgrades, and system configurations that will mitigate significant security vulnerabilities and enforce a consistent process across all field offices; and
- Improve performance monitoring to ensure controls are operating as intended at all facilities and communicate identified security deficiencies to the appropriate personnel so they can take corrective actions to mitigate significant security risks.

Further, although VA has made measurable progress in implementing recommendations from prior audits, a recommendation from the FY 2006 audit pertaining to background investigations and reinvestigations for staff occupying sensitive IT positions is still pending.

VA'S PROGRAM RESPONSE

Estimated Resolution Time Frame: October 1, 2019

Responsible Agency Officials: Assistant Secretary for OIT and CIO

Since the 2018 OIG FISMA audit report, VA continues to take proactive steps to address security-related issues and improve upon its organization-wide security program—focusing on information security, cybersecurity, and privacy throughout the enterprise. VA utilizes ECSP to align with VA's mission and core values; strengthen risk management processes in compliance with Executive Order 13800, "Strengthening the Cybersecurity of Federal Network and Critical Infrastructure"; support business strategic modernization initiatives inclusive of financial systems; and provide innovative cybersecurity solutions that protect the veteran in alignment with FISMA. VA has also aligned to both the National Institute of Standards and Technology (NIST) Risk Management Framework (RMF) and the NIST Cybersecurity Framework (CSF) to manage the agency's cybersecurity risk. CSF provides VA with greater visibility into risk at the enterprise level, while RMF provides visibility into risk at the system level.

To address security-related issues that contributed to the IT material weakness, VA has implemented 33 compensating controls, along with remediation activities that reduce risks to an acceptable level. These activities provide additional mitigation of identified risks as well as strengthening the operating

capabilities of controls across the organization. The implementation of the compensating controls involves collaboration across VA to address and mitigate identified deficiencies and is intended to prepare VA ahead of the next audit cycle beginning on October 1, 2019.

To mitigate security vulnerabilities and enforce a consistent process across all field offices, VA has established a Vulnerability Management Program, which provides centralized oversight of vulnerability monitoring and response processing spanning across VA facilities, medical centers, central office, ROs, and remote field operations. Since the program started, 65 million vulnerabilities have been remediated, accounting for a 66 percent reduction in aged vulnerabilities. ECSP has also prioritized cybersecurity projects and established accountable offices, assigned roles and responsibilities for delivery, and implemented mechanisms for tracking and monitoring the success of each project through closure. Programs and projects were prioritized to address the following identified activities:

- Security patches improving upon the software that is required for VA applications, accelerating VA's current remediation patch process. Since 2015, VA has achieved a 75 percent reduction in time to patch, measuring at 98 percent remediation.
- System upgrades via efforts such as the implementation of a new Governance, Risk, and Compliance tool that automates security documentation and enables greater visibility into cyber risks.
- System configurations through enhancements to VA's Configuration Management program addressing system development and change management processes.

In alignment with these efforts, VA has documented 54 original baselines as well as conducted 596 annual baseline reviews.

VA has also improved upon performance monitoring to validate that controls are operating as intended by continuing the implementation of VA's Information Security Continuous Monitoring/Continuous Diagnostic Monitoring Cybersecurity Project. This enables VA to maintain situational awareness of its security posture and make informed, timely security decisions. As of August 2019, 95 percent of sites had implemented ForeScout and supporting policies are active. Additionally, the incorporation of the RMF permits VA to monitor and analyze compliance, measure operational risk, and ultimately make risk-based determinations for an information system's Authority to Operate. This allows VA to enforce continuous evaluations and monitor identified vulnerabilities to identify the appropriate personnel that take corrective actions to mitigate significant security risks.

The estimated resolution time frame is October 1, 2019, based on the planned completion of compensating control activates addressing the cybersecurity risks identified in the OIG material weakness findings, which would be reduced to an acceptable level.

MITIGATING RISKS AND POOR OUTCOMES CAUSED BY INFORMATION TECHNOLOGY PLANNING AND IMPLEMENTATION

Recent OIG reviews demonstrate that new IT must be introduced thoughtfully to mitigate risks to patients. This conclusion builds on an independent assessment that inadequate collaboration between VA's centralized IT organization and VHA has led to a failure to prioritize IT capabilities that support VHA's needs. For example, in *Delayed Radiology Test Reporting at the Dwight D. Eisenhower VA Medical Center in Leavenworth, Kansas*, the OIG reported that radiologists did not receive training on new software that generates alerts regarding abnormal test results. This was problematic because missing

alerts were cited as a factor that contributed to providers' failure to timely communicate those results and the need for clinical follow-up. Although action is underway to correct the issues at the medical center, VA will need to scale training and risk-mitigation strategies systemwide as it implements the new EHR system.

The modernization effort will also need to take into consideration prior OIG concerns about opioid prescribing coordination, particularly between VA facilities and care in the community, as well as avoiding lag times in sharing records (as evidenced by large backlogs in scanning documentation into patient records).

IT problems can also have a serious effect on veterans, their dependents, and caregivers when benefits are inappropriately delayed, canceled, or inaccurately calculated. Following the OIG report on P*rogram of Comprehensive Assistance for Family Caregivers: Management Improvements Needed*, in which missteps are detailed in the program's planning and implementation, the OIG continues to conduct oversight work on whether VHA takes timely and consistent action to appropriately discharge veterans and their caregivers from the program. This includes actions to subsequently cancel caregiver stipend payments following a veteran's or caregiver's death, or the veteran's incarceration or hospitalization.

With the expansion of the program under the VA MISSION Act, there will be additional stresses on VHA to make IT improvements that help ensure it avoids, identifies, and promptly resolves improper payments to caregivers due to deaths, incarcerations, or relevant hospitalizations of veterans.

VBA also discontinued the Decision Ready Claims Program, which the OIG found was hindered by ineffective planning and lack of stakeholder involvement. VSOs had issues accessing the appropriate systems to file the claims and lacked resources to fill their anticipated role in helping veterans prepare required documents. Overall, claim filing time was not found to be reduced. Discontinuing the program should allow VBA to refocus on more successful strategies and to use the lessons learned from this program to inform future planning.

VBA also struggled to implement key provisions of the Forever GI Bill that affected veterans' housing allowance payments, because VA lacked an accountable official to oversee the IT system implementation during most of the effort. This lack of oversight resulted in unclear communication of implementation progress and inadequately defined expectations, roles, and responsibilities of the various VA business lines and contractors involved. VBA has since put in place efforts to ensure that education claims are processed in accordance with the new law and that beneficiaries retroactively receive affected benefits, which will be monitored by the OIG.

VA'S PROGRAM RESPONSE

Estimated Resolution Time Frame: Various

Responsible Agency Officials: Assistant Secretary for OIT and CIO, USH, USB

This challenge is covered by multiple VA organizations: OIT, VHA, and VBA. The organizations have responded specifically to those parts of the challenge that pertain to them.

OIT's Response

Since the 2018 OIG FISMA Audit report, VA continues to take proactive steps to address security-related issues and improve upon its organization-wide security program—focusing on information security, cybersecurity, and privacy throughout the enterprise. VA utilizes the ECSP to align with VA's

mission and core values; strengthen risk management processes in compliance with Executive Order 13800, "Strengthening the Cybersecurity of Federal Network and Critical Infrastructure"; support business strategic modernization initiatives inclusive of financial systems; and provide innovative cybersecurity solutions that protect the veteran in alignment with FISMA. VA has also aligned to both the NIST RMF and the NIST CSF to manage the agency's cybersecurity risk. CSF provides VA with greater visibility into risk at the enterprise level, while RMF provides visibility into risk at the system level.

To address security-related issues that contributed to the IT material weakness, VA has implemented 33 compensating controls, along with remediation activities that reduce risks to an acceptable level. These activities provide additional mitigation of identified risks as well as strengthening the operating capabilities of controls across the organization. The implementation of the compensating controls involves collaboration across VA to address and mitigate identified deficiencies and is intended to prepare VA ahead of the next audit cycle beginning on October 1, 2019.

To mitigate security vulnerabilities and enforce a consistent process across all field offices, VA has established a Vulnerability Management Program, which provides centralized oversight of vulnerability monitoring and response processing spanning across VA facilities, medical centers, central office, ROs, and remote field operations. Since the program started, 65 million vulnerabilities have been remediated, accounting for a 66 percent reduction in aged vulnerabilities. ECSP has also prioritized cybersecurity projects and established accountable offices, assigned roles and responsibilities for delivery, and implemented mechanisms for tracking and monitoring the success of each project through closure. Programs and projects were prioritized to address the following identified activities:

- Security patches improving upon the software that is required for VA applications, accelerating VA's current remediation patch process. Since 2015, VA has achieved a 75 percent reduction in time to patch, measuring at 98 percent remediation.
- System upgrades via efforts such as the implementation of a new Governance, Risk, and Compliance tool that automates security documentation and enables greater visibility into cyber risks.
- System configurations through enhancements to VA's Configuration Management program addressing system development and change management processes. In alignment with these efforts, VA has documented 54 original baselines as well as conducted 596 annual baseline reviews.

VA has also improved upon performance monitoring to validate that controls are operating as intended by continuing the implementation of VA's Information Security Continuous Monitoring/Continuous Diagnostic Monitoring Cybersecurity Project. This enables VA to maintain situational awareness of its security posture and make informed, timely security decisions. As of August 2019, 95 percent of sites had implemented ForeScout and supporting policies were active. Additionally, the incorporation of the RMF permits VA to monitor and analyze compliance, measure operational risk, and ultimately make risk-based determinations for an information system's Authority to Operate. This allows VA to enforce continuous evaluations and monitor identified vulnerabilities to identify the appropriate personnel that take corrective actions to mitigate significant security risks.

The estimated resolution time frame is October 1, 2019, based on the planned completion of compensating control activates addressing the cybersecurity risks identified in the OIG material weakness findings, which would be reduced to an acceptable level.

VHA's Response

In reference to OIG 17-04003-222, the *Program of Comprehensive Assistance for Family Caregivers (PCAFC): Management Improvements Needed*, two of the six recommendations identified by the OIG have been closed. Recommendations 2, 3, 4, and 6 remain open and are targeted to be completed by the end of FY 2019.

To address Recommendation 1, VHA Directive 1152 was amended to include 14 standard operating procedures governing the delivery of PCAFC. Guidance is inclusive of PCAFC monitoring requirements, expectations for documenting changes in veteran's functioning and degree of need including tier changes and discharge from PCAFC based on no longer meeting eligibility, as well as ensuring facilitation of referrals to appropriate supports and services. VHA wishes to note that in December 2018, VA issued a temporary suspension on reassessments leading to discharges or decreases in tier level and this suspension remains in effect. Eligibility determinations for PCAFC are complex and historically application processing times have resulted in delayed decisions. In the second quarter of FY 2019, a VHA-wide performance metric was established with a goal of processing 90 percent more applications within 90 days or less. Through July 2019, 88.90 percent of application decisions have been made in less than 90 days during the fiscal year.

As part of Recommendation 1 and Recommendation 5, the OIG recommended the establishment and strengthening of a governance structure to monitor and oversee the administration of PCAFC. VHA has established a VISN Lead at every VAMC with a specific point of contact at each VISN office to ensure workload monitoring, provide guidance, coaching, and support to Caregiver Support Coordinators (CSC) within the VISN and ensure compliance with national policy and procedures. Both recommendations 1 and 5 are closed.

To improve accuracy of eligibility determinations as noted as an area for improvement in Recommendation 2, VHA has developed and implemented a required clinical eligibility training for all new CSCs and VISN leads, as well as a required annual refresher training for CSCs and VISN leads. An annual training for all providers who participate in eligibility decisions has been developed and is pending deployment.

To address Recommendation 3, the need for a well-defined process for documenting changes in veterans' health conditions during monitoring sessions to determine if those changes warrant a reassessment of the need for care or the level of care, a standardized process for documenting changes in veterans' health conditions during monitoring sessions was deployed as part of the VHA Directive update and also as a training on monitoring expectations to include guidance on the type and frequency of monitoring assessments, documentation of such assessments, and communication of such assessments to participants of the PCAFC was delivered to the CSC field in January 2019. To support accurate documentation of these actions, a toolkit was developed and deployed to the field in August 2019 to provide an additional resource for field-based staff in support of accurate data capture.

The OIG further recommended that VHA should establish assessment guidelines that caregiver support coordinators should follow when a veteran's need for care changes. An SOP is in development.

In response to the OIG's recommendation to assess adequacy of staffing levels needed to implement PCAFC as intended, VHA has developed a staffing model to support PCAFC at local facilities based on facility complexity, type (rural/urban), and number of approved participants. This recommended staffing model can be adjusted at the local level to allow VISNs the ability to base staffing on individual

facility needs. Guidelines were disseminated to VISN Directors in Q3 2019, and Networks were given the opportunity to request staffing to meet the capabilities required for the Caregiver Support Program (CSP). The VISN CSP leads, the national CSP program office reviewed the requests, and the majority of the requested positions were approved as they were supported by the staffing model. Notification to the field for these approvals was completed in August 2019 so that hiring can commence. Staffing is just one aspect of ensuring that the PCAFC is implemented as intended. In addition to disseminating application processing time metrics to Network directors this fiscal year, as identified earlier in this update, a Key Performance Metric report is disseminated quarterly to national CSP Managers demonstrating numbers of applications, approvals, denials, revocations, and timeliness of application determinations.

In reference to OIG 18-00980-84, *Delayed Radiology Test Reporting at the Dwight D. Eisenhower VA Medical Center, Leavenworth, Kansas*, all five [recommendations] remain open. The facility has completed the following: updated local policies for Reporting Critical and Abnormal Imaging Test Results and Protected Peer Review to align with current VHA directives, provided training to radiologists on the national diagnostic codes and the software that triggers view alerts, completed a management review of the provider, and performed an institutional disclosure to the veteran. A request for closure was submitted for all five recommendations on July 1, 2019.

VBA's Response

VBA continues to evolve its IT program risk management capabilities. In partnership with VA's OIT, VBA is continuing to adopt agile development practices in concert with OIT Enterprise Project Management efforts. Across the spectrum of VBA IT initiatives, agile development practices continue to identify avenues for the development and production release of improved IT systems.

VBA is continually refining its governance practices and has adopted leadership driven forums to improve the collaboration with IT. The Benefits Systems Accountability Board routinely drives improved risk management and operational adjustments to VBA and OIT initiatives to improve service to veterans and their dependents. OIT has improved its collaboration with VBA through improved practices adopted by its account management strategies.

In addition to improved development practices and improved governance capabilities, VBA and OIT are partnering in establishing OIT's ERM Framework. OIT's ERM Strategy and OIT's ERM Framework adhere to Federal regulations and mandates, including OMB Circular No. A-123, which requires agencies to implement an ERM capability that aligns to strategic planning and strategic review processes as established by the Government Performance and Results Act Modernization Act of 2010. The goal of ERM is to identify, assess, report, mitigate, and monitor risks affecting VBA's ability to carry out its mission. Altogether, improved agile development practices, improved governance capabilities, and expanded ERM capabilities continue to evolve and add key features to improve accountability and oversight of the development and deployment of VBA IT systems.

In February 2019, VA awarded a Software Development and Systems Integration contract to Accenture Federal Services to make the necessary IT changes and updates to support processing of education benefits under the Post-9/11 Veterans Educational Assistance Act of 2008 (Post- 9/11 GI Bill) and the Colmery Act. VA is on track to deploy the IT solution on December 1, 2019, for sections 107 and 501 of the Colmery Act. VBA anticipates meeting this challenge and addressing all existing beneficiaries in FY 2020.

To ensure this project remains on schedule, VBA established an Executive Steering Committee (ESC) consisting of senior leaders from OIT, VBA's Education Service (EDU), and VBA's Office of Business

Process Integration (OBPI). The ESC meets weekly to review the implementation's progress, resolve any challenges or blockers to success, and ensure proper communication is occurring across this enterprise effort. Additionally, a Program Integration Office (PIO) was established with support from MITRE and includes staff from OIT, EDU, and OBPI. The PIO is responsible for all daily work related to the Colmery Act's implementation.

KEY RELATED LINKS

- OIG Statement for the Record, "Mission Critical: Caring for Our Heroes," May 22, 2019.
- OIG Congressional Testimony, "Mapping the Challenges and Progress of the Office of Information and Technology," April 2, 2019.
- OIG Report, Federal Information Security Modernization Act Audit for Fiscal Year 2018, Report No. 18-02127-64, March 12, 2019.
- OIG Report, Delayed Radiology Test Reporting at the Dwight D. Eisenhower VA Medical Center, Leavenworth, Kansas (VA Eastern Kansas Health Care System), Report No. 18-00980-84, March 7, 2019.
- OIG Report, Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed, Report No. 17-04003-222, August 16, 2018.
- OIG Report, Decision Ready Claims Program Hindered by Ineffective Planning, Report No. 18-05130-105, May 21, 2019.
- OIG Congressional Testimony, "Examining Ongoing Forever GI Bill Implementation Efforts," May 9, 2019.
- OIG Issue Statement, Forever GI Bill: Early Implementation Challenges, Report No. 19-06452-97, March 20, 2019.
- The MITRE Corporation, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume I: Integrated Report, September 1, 2015.

APPENDIX: MAJOR MANAGEMENT CHALLENGES AT A GLANCE

Major Management Challenge		Estimated Resolution Time Frame (Fiscal Year)
No.	**Description**	
OIG 1	**Strengthening Leadership and Workforce Investment**	
	Overcoming a Culture of Complacency	Ongoing
	Addressing Key Leadership Vacancies and Other Staffing Shortages	2021
	Investing in Workforce Development	2020
OIG 2	**Improving Health Care Access and Quality of Care**	
	Improving Quality of Care	2020
	Enhancing Access to Care	2021
	Ensuring That Effective Core Services Are Available to Promote Quality and Timeliness of Care	2019
OIG 3	**Ensuring the Accuracy and Timeliness of Benefit Services**	
	Improving the Accuracy and Timeliness of Claims Decisions and Appeals	2020
	Identifying and Mitigating the Risk of Benefits-Related Fraud, Waste, and Abuse	2020
	Effectively and Efficiently Administering Education and Other Benefits	2020
OIG 4	**Enhancing Financial Management and Controls**	
	Improving Financial Controls	Ongoing
	Reducing Improper Payment Rates	2022
	Improving Management of Appropriated Funds	Resolved
OIG 5	**Overseeing the Compliance and Integrity of Procurement Practices**	
	Improving Contracting Practices	Ongoing
	Improving Purchase Card Practices	2021
OIG 6	**Minimizing Risks and Increasing Effectiveness for Information Management Systems**	
	Ensuring Effective Information Security Program and System Security Controls	2019
	Mitigating Risks and Poor Outcomes Caused by Information Technology Planning and Implementation	Various