

SECTION A: MANAGEMENT CHALLENGES

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

FOREWORD

The mission of the Department of Veterans Affairs is to serve America's veterans and their families with dignity and compassion. VA also works to ensure that veterans receive the care, support, and recognition earned in service to our Nation. VA has three administrations that serve veterans: Veterans Health Administration, Veterans Benefits Administration, and the National Cemetery Administration. These administrations must provide services and benefits in a way that best meets the needs of all veterans. It is vital that they work in tandem with support services like financial management, procurement, and information management to maximize their effectiveness and efficiencies.

The Office of Inspector General's (OIG) mission is to serve veterans and the public by conducting effective oversight of the programs and operations of VA through independent audits, inspections, investigations, and reviews. The OIG also recommends improvements in VA programs and operations, and acts to deter and detect waste, fraud, and abuse. Each year, pursuant to Section 3516 of Title 31, United States Code, OIG provides VA with an update summarizing the most serious management and performance challenges identified by OIG work, as well as an assessment of VA's progress in addressing those challenges.

This report contains the updated summation of the major management challenges and high-risk areas facing the Department within OIG's six strategic goals—health care delivery, benefits processing, financial management, procurement practices, information management, and workforce investment—with assessments of VA's progress on implementing OIG recommendations.

OIG will continue to work with VA to address these issues to ensure the best possible service and benefits to our Nation's veterans and their families, and to ensure appropriate expenditure of taxpayer money.



MICHAEL J. MISSAL
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Major Management Challenge		Estimated Resolution Time frame (Fiscal Year)	Page #
No.	Description (Responsible Office)		
OIG 1 Health Care Delivery (VHA)			
1A	Quality of Care (VHA)	Various	167
1B	Access to Care (VHA)	2019	178
OIG 2 Benefits Delivery (VBA)			
2A	Improving the Accuracy and Timeliness of Claims Decisions (VBA)	2017	185
2B	Improving Data Integrity, Internal Controls, and Management Within VA Regional Offices (VBA)	2017	189
OIG 3 Financial Management (Lead: OM, contributing: OI&T, VHA, and VBA)			
3A	Compliance with the Improper Payments Elimination and Recovery Act (OM, VHA, VBA, and OALC)	2020	191
3B	Improving Financial Reporting (OM, VHA, VBA, and OI&T)	2020	193
3C	Improving Management of Appropriated Funds (Lead: OM, contributing: OI&T and VHA)	2020	194
OIG 4 Procurement Practices (Lead: VHA, contributing: OM and OI&T)			
4A	Improving Contracting Practices (Lead: VHA, contributing: OM and OI&T)	Ongoing	197
4B	Improving Purchase Card Practices (Lead: VHA, contributing: OM and OI&T)	Ongoing	198
OIG 5 Information Management (OI&T)			
5A	Effective Information Security Program and System Security Controls (OI&T)	2017	200

OIG CHALLENGE #1: HEALTH CARE DELIVERY

STRATEGIC OVERVIEW

The VHA continues to face significant challenges in delivering timely and quality health care to patients. The OIG publications in fiscal year (FY) 2017 highlight the complexity of these challenges.

The opioid epidemic continues to impact veterans, and overdose deaths among veterans remain elevated when compared to the civilian population.¹ Considering the unique experience of veterans, it is not surprising that so many suffer from some form of chronic pain. Pain management becomes even more complicated when a patient's chronic pain occurs in the setting of comorbidities prevalent in the veteran population, such as post-traumatic stress disorder, depression, traumatic brain injury (TBI), and substance abuse disorder. This year, OIG published reports evaluating opioid prescribing practices in VHA.

With continued expansion of the VCP provider network, care continuity and coordination continue to challenge both VHA providers and patients. During FY 2017, OIG published multiple reports documenting persistent access to care concerns, including delays in patients receiving needed care within the system and also within the community. OIG found that many of the delays were attributable to staff not adhering to consult policies and procedures, limited availability of in-house and community

specialists, and lack of efficiency and timeliness in authorizing community care for patients.

Suicide remains one of the most serious public health concerns. As a medical, psychiatric, and social issue, it is accentuated in the veteran population. Based on 2014 data, VA estimated that the number of veteran deaths by suicide averaged 20 per day. This number significantly exceeds the national average. The Veterans Crisis Line (VCL) was established in 2007 to provide suicide prevention and crisis intervention to veterans, Servicemembers, and their family members. OIG reported in FY 2017 that the VCL continues to face significant operational challenges as it strives to carry out its mission.

Instability and prolonged vacancies in key VHA leadership positions pose additional challenges to quality health care delivery. This year, OIG published two reports with key findings attributable to vacant critical leadership positions.

OIG SUB-CHALLENGE #1A: QUALITY OF CARE (VHA)

1. PROMOTING SAFE OPIOID PRESCRIBING PRACTICES

Overdose deaths involving prescription opioids have quadrupled since 1999. In 2015, more than 22,000 people died from overdoses involving prescription opioids.² With increasing opioid overdose deaths, the emphasis on opioid prescribing has shifted to opioid dose reduction, increased assessment, and monitoring of patients on chronic opioid therapy. While prescribing practices continue to vary within VA

¹ Bohnert AS, Ilgen MA, Galea S, McCarthy JF, Blow FC. "Accidental poisoning mortality among patients in the Department of Veterans Affairs Health System." *Med Care*. April 2011 49(4) 393-396; 4:393-396.

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and the Nation, two initiatives implemented within VHA, the Opioid Safety Initiative (OSI) and the enabling of VHA providers to participate in state prescription drug monitoring programs (PDMPs)², have armed VA prescribers with tools aimed at limiting high-dose chronic opioid therapy, concurrent use of benzodiazepines and opioids, and patients receiving opioid prescriptions from multiple providers.

VA's Program Response

Estimated Resolution Timeframe: 2018

Responsible Agency Official: Under Secretary for Health

Associated Strategic Goal: Empower Veterans to improve their well-being

Strategic Objective: Improve Veteran wellness and economic security

Associated Performance Measure(s): No public-facing measures are associated with this issue

FY 2017 Milestones:

During FY 2017, VHA continued the full implementation of the OSI system-wide. Significant milestones include the publication of the VA/ DoD Clinical Practice Guideline, *Management of Opioid Therapy for Chronic Pain*, in February 2017, which recommends against initiation of long-term therapy for chronic pain patients and gives providers clear and evidence-based guidance for risk mitigation strategies. VHA continued to expand education and training of providers in regard to the transformation in pain care within VHA through

² PDMPs are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients.

a variety of strategies. Clinical providers completed a mandated training about the risks associated with opioid prescribing and assessment and treatment of opioid use disorder by April 15, 2017. The VA and DoD issued the Joint Pain Education Program for training of primary care teams and continue to update the modules. The Academic Detailing Program expanded systemwide in 2017 and provides individual monitoring and feedback to clinicians about opioid prescribing, implementation of risk mitigation strategies, and in particular, prescribing of naloxone as opioid overdose rescue. The Opioid Overdose Education and Naloxone Distribution (OEND) program has been expanded to all sites, and 88,188 prescriptions for Naloxone were filled as of June 2017. The VHA PDMP directive was issued in October 2017, mandating the checking of state PDMP's for VA providers in all available states. Forty-seven states and the District of Columbia are activated for VA data transmission to their PDMP. Since Quarter 3, FY 2013, VA providers have documented over 2 million queries to PDMPs to help guide treatment decisions. Facilities and clinical providers are supported by several dashboards, and risk assessment and identification tools for care coordination include improvements in the Opioid Therapy Risk Report and Stratification Tool for Opioids Risk Mitigation. VHA developed standards for interdisciplinary pain management teams at all facilities to include integrated access to addiction medicine. All facilities were mandated to identify pain team members. During FY 2017, VHA developed and delivered the plan to expand the scope of Complimentary and Integrative Health (CIH) services in the VA to include the selection of CIH Whole Health flagship pilot sites in each VISN to begin operations in FY 2018. Thus, VHA is in process to fully implement the requirements by the Comprehensive Addiction and Recovery Act.

Peer Reviewed Medical Literature— Published in Medical Journals

VA's efforts in opioid safety and risk management were highly represented in medical literature. An example of the articles and research studies is included below.

JAMA Internal Medicine published an article authored by Walid F. Gellad, MD, MPH; Chester B. Good, MD, MPH; and David J. Shulkin, MD reviewing the lessons learned during the VA's effort's to address the opioid epidemic. The article provides data and research related to the VA's efforts to address the opioid epidemic in an effort to inform other health care systems planning comprehensive actions to reduce risks associated with opioid therapy. The authors reviewed the broad strategies of education, pain management, risk mitigation, and addiction treatment.

Journal of the American Pharmacists Association published a paper by Dr. Oliva, et al., titled "Opioid overdose education and naloxone distribution: Development of the VHA national program." The paper addresses key risk areas in the prevention of opioid overdoses nationally through the implementation of the OEND program. Dr. Oliva, and others, concluded that "VHA has successfully translated community-based OEND into health care system-based program targeting 2 patient populations".

PAIN published an article by Dr. Lin, et al., titled "Impact of the OSI on opioid-related prescribing in Veterans." This study examined the changes associated with the OSI implementation at the VA. The authors found the implementation of a national health care systemwide initiative was associated with reductions in outpatient prescribing of risky opioid regimens. The findings provided evidence for the potential utility of large-scale interventions to promote safer opioid prescribing.

VA DATA

From the peak of opioid prescribing in VHA in 2012, VHA achieved significant improvements in all opioid prescribing parameters of the OSI. This includes a reduction of Veterans on long-term opioid therapy by 41 percent (Quarter 4 FY 2012 to Q3 FY 2017) and a reduction of opioid and benzodiazepine used in combination by 64 percent over the same time period. Further improvements are anticipated in the coming years. VHA's efforts should provide safe and effective pain care and lessen the reliance on opioid medication, while specifically targeting the needs of the Veterans at risk for or with opioid use disorder, will require a sustained effort for the foreseeable future.

The OSI key clinical metrics measured from Quarter 4 FY 2012 (beginning in July 2012) to Quarter 3 FY 2017 (ending in June 2017) demonstrate VA's success: 240,269 fewer patients receiving opioids (679,376 patients to 439,107 patients, a 35 percent reduction), 78,112 fewer patients receiving opioids and benzodiazepines together (122,633 patients to 44,521 patients, a 64 percent reduction), and 181,232 fewer patients on long-term opioid therapy (438,329 to 257,097, a 41 percent reduction); patients on long-term opioid therapy with a urine drug screen completed in the last year to help guide treatment decision has increased from 37 percent to 87 percent (50 percent increase); and the overall dosage of opioids is decreasing in the VA system as 31,154 fewer patients (59,499 patients to 28,345 patients, a 52 percent reduction) are receiving greater than or equal to 100 morphine equivalent daily dose. The desired results of the OSI have been achieved during a time that VA has seen an overall growth of 171,634 patients (3,959,852 patients to 4,131,486 patients, a 4 percent increase) who have utilized VA outpatient pharmacy services.

Comparison of CMS and VA Data

VA's own data, peer reviewed medical literature, and the Centers for Medicare and

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Medicaid Services (CMS) suggest that VA is making progress relative to the rest of the Nation.

Sales of prescription opioids have nearly quadrupled in the United States from 1999 to 2014. The most recent opioid utilization data available for comparison to VA is CMS data for Part D beneficiaries, which are available from CY 2013 to CY 2016. On April 3, 2017, CMS notified Medicare Advantage organizations, prescription drug plan sponsors, and other interested parties of opioid utilization rates for Part D beneficiaries for CY 2013 through CY 2016, which VA used to make its comparison. There are several factors to consider when comparing CMS Part D to VA health care such as (1) since CMS Part D is a payer of care and VA is predominantly a direct provider of care, VA has the ability to control utilization better than CMS; (2) CMS Part D beneficiaries are predominately over the age of 65; and (3) although 50 percent of VA patients are over 65 years of age, VA's beneficiary population is characterized as having multiple co-morbidities and a very heavy disease burden.

Although annual data is not able to show the impact of organizational change as well as quarterly data can, the annual data in Table 1 demonstrates both CMS Part D and VA have experienced success reducing the percentage of enrollees utilizing opioids over time. From 2013 to 2016, the percentage of CMS Part D and VA enrollees utilizing opioids decreased by 1.6 percent and 2.6 percent, respectively. The total number of CMS Part D enrollees utilizing opioids increased 9.2 percent (11,794,908 to 12,885,620), while the total number of VA enrollees utilizing opioids decreased 15.3 percent (1,417,969 to 1,201,624).

However, the percent change in the number of enrollees utilizing opioids needs to be taken in context with the overall growth of enrollees between the two systems. CMS Part D has experienced a higher rate of growth of 15.1 percent (37,842,632 to 43,569,035) of enrollees, while the VA health care system only experienced a 1.3 percent rate of growth (8,926,610 to 9,046,663) of enrollees.

Table 1: CMS Part D and VA Opioid Utilization Rates, 2013 - 2016

Year*	Total CMS Part D Enrollees	Total CMS Part D Enrollees Utilizing Opioids**	% CMS Part D Enrollees Utilizing Opioids***	Total VA Enrollees	Total VA Enrollees Utilizing Opioids	% VA Enrollees Utilizing Opioids
2013	37,842,632	11,794,908	31.2	8,926,610	1,417,969	15.9
2014	39,982,962	12,308,735	30.8	9,093,511	1,395,926	15.4
2015	41,835,016	12,510,448	29.9	8,965,923	1,299,968	14.5
2016	43,569,035	12,885,620	29.6	9,046,663	1,201,624	13.3
					812,219 [#]	9.0% [#]

*CMS Part D data is CY (January to December) and VA data is fiscal year (October to September).

**CMS data excludes cancer and hospice patients for all years, while VA data only breaks out cancer/hospice/palliative care patients for 2016. The effect of this difference is that VA's success in reducing the utilization of opioids is under-reported.

***CMS Part D enrollees utilizing opioid excludes hospice and cancer patients.

VA enrollees utilizing opioids excludes hospice and cancer patients for 2016.

In reference to the OIG site-specific report, *Healthcare Inspection – Patient Deaths, Opioid Prescribing Practices, and Consult Management, VA Greater Los Angeles*

Healthcare System (15-01669-246), the site completed the following actions in FY 2017. OIG closed one recommendation. The facility implemented a number of corrective actions to

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address the OIG recommendations, including ongoing monitoring of consult compliance with VHA policies until 90 percent compliance is achieved for three consecutive months.

In reference to the OIG site-specific report, *Healthcare Inspection – Opioid Prescribing Practice Concerns, VA Illiana Health Care System, Danville, Illinois (16-00462-192)*, no recommendations were made and there were no substantiated allegations.

2. CARE CONTINUITY AND COORDINATION

Care coordination is an activity aimed at ensuring that a patient's needs are met during transitional periods of their health care, e.g., coordination of care between a primary care provider and a specialist, between different health care organizations, or transitions over periods of time such as the transition between a new patient appointment to a follow-up appointment. To ensure seamless continuity of care, the flow of critical patient information must occur in a timely manner. Within VA, business rules are in place to direct the processing and scheduling of electronic requests for clinical consults. These business rules direct consult processing and scheduling for both VA care as well as care requested through VA-purchased care providers.

VA's Program Response

Estimated Resolution Timeframe: 2020

Responsible Agency Official: Under Secretary for Health

Associated Strategic Goal: Empower Veterans to improve their well-being; manage and improve VA operations to deliver seamless and integrated support

Strategic Objective: Increase customer satisfaction through improvements in benefits and service delivery policies, procedures, and interfaces

Associated Performance Measure(s):

Organization's leaders maintain high standards of honesty and integrity:

- Percent of patients who responded "Always" regarding their ability to get an appointment for a routine checkup as soon as needed
- Percent of patients who responded "Always" regarding their ability to get an appointment for needed care right away
- OPM Federal Employee Viewpoint Survey Employee Engagement Index Score
- Employees feel encouraged to come up with new and better ways of doing things
- Employees have a feeling of personal empowerment with respect to work processes.

FY 2017 Milestones:

VA is committed to providing first-class health care to our Veterans, whether they are at their home VA facility, receiving care in the community, or traveling. VA is working to optimize the experience for Veterans needing care from an alternate VA facility while traveling or relocating. Seamless Care is now one of the Department's breakthrough initiatives under improving access to health care. With the Seamless Care for Traveling Veterans program, such care is possible. Veterans enrolled in the VA health care system can contact their patient aligned care team or specialty care provider when traveling or temporarily experiencing a change of address - such as living in one state during the winter and another during summer - to ensure a smoother experience, if health care is needed along the way at an alternate VA facility. The Seamless Care for Traveling Veterans program helps to ensure patients' needs are consistently met during transitional periods of their health care. In 2015, the Seamless Care for Traveling Veterans program had 1,500 consults initiated. Based on data for the current year to date, the program is projected to grow to approximately 22,000 consults in calendar 2017.

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VHA Handbook 1101.11(2), *Coordinated Care Policy for Traveling Veterans*, was published on April 22, 2015. As of January 2016, each facility has indicated compliance with key requirements. Veterans do not need to re-enroll but will be registered at the alternate facility. This process has been streamlined at VAMCs and CBOCs so that multiple staff can re-register a Veteran on a 24/7 basis. There is a clinically trained Traveling Veteran Coordinator at each medical center to facilitate the care needs of traveling Veterans. Arrangements can now be made in advance to facilitate the care of the Veteran. An established process is now in place for pharmacists to provide a bridge supply of medications for onetime visits away from the home facility.

As part of the OCC's continued goal to provide timely access to care through care continuity and coordination, a new operating model for referral and management of care in the community has been deployed. The new operating model is the future state vision for VA's OCC, to operate as a "clinic within a clinic," elevating local community care offices to a clinical department within the medical center and aligning the organization to clinical leadership to support the focus on providing care and care coordination for Veterans. The new operating model provides facilities processes that establish an oversight council, allows for alignment under clinical leadership, standardizes position descriptions, establishes integrated teams, and provides tools that enhance the ability to manage care in the community. Currently, there are 18 sites that are working through this process. Each of the 18 sites has a comprehensive implementation team and facility-specific plans. Each team includes a transformation lead at the site, field support staff, and a regional director who assists with all aspects of the operating model. All available tools have been implemented at each of the phased implementation sites as appropriate in accordance with the local IT/information security officer.

The OCC provided training that outlines the preparatory work needed to successfully adopt the One Consult Model at local sites. The One Consult Model transforms the processes and policies for consult management, allowing forwarding capabilities of an in-house consult to a community care consult and back to the initial clinic-related consult title as needed. This model will enhance the end-to-end process of consult management by utilizing the Consult Toolbox functionality to track and document consult reviews, updates, forwards, appointment information, and consult closures throughout the life cycle of the consult. Training was conducted in July 2017 and August 2017 to provide technical steps and instructions on how to implement the model to include necessary consult template changes and process configurations.

VA's consult process requirements currently specify that a complete up-to-date list of medications and all applicable medical history information (e.g., prior pain management treatment, controlled substance agreements, applicable behavior health flags) be included with community care consults sent to the VA third-party administrators and shared with VA community care providers. The OCC has recently implemented a medical documentation tool that simplifies the process of gathering and organizing all applicable medical history information and a complete up-to-date list of medications into one uniform document. The Referral Documentation (REFDOC) tool compiles a package of documentation, including a comprehensive medications list of outpatient and pain management meds dispensed by VA in the last 12 months and current medications prescribed by non-VA sources that are recorded in the VA data warehouse. This electronic tool is being implemented, with full implementation to be completed by late 2017.

In reference to the OIG site-specific report, *Healthcare Inspection – Consult Management*

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Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California (15-04681-228), the VA Greater Los Angeles Healthcare System completed the following actions in FY 2017. OIG closed recommendation 4. The facility implemented a number of corrective actions to address the OIG recommendations, including monitored accuracy of setting and urgency for consults, monitored timely closure/discontinuation of consults, and monitored and addressed the care needs of patients on the Electronic Wait List.

In reference to the OIG site-specific report, *Healthcare Inspection – Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana (16-00621-175)*, the site completed the following actions in FY 2017. The facility requested closure on the three remaining recommendations. The facility implemented several corrective actions to address the OIG recommendations, including submitted the results of external peer review, and documented consultation with General Counsel about disclosure of adverse events and data on consult timeliness.

3. ENSURING VCL RESPONSIVENESS AND QUALITY

The primary mission of the VCL is “to provide 24/7, world-class suicide prevention and crisis intervention services to Veterans, Servicemembers, and their family members.” The VCL faces a number of challenges. They must meet the operational and business demands of responding to over 500,000 calls per year, along with thousands of electronic chats and text messages, and initiating rescue processes when indicated. They must also train staff to respond to Veterans and their family members in individual encounters during which a responder must make an accurate assessment of the needs of the caller under stressful, time-sensitive conditions. Further, they must ensure that clinicians are actively and appropriately involved in the governance of the

VCL to ensure necessary involvement of all stakeholders.

VA’s Program Response

Estimated Resolution Timeframe: FY 2018

Responsible Agency Official: Under Secretary for Health

Associated Strategic Goal: Empower Veterans to improve their well-being

Strategic Objective: Increase customer satisfaction through improvements in benefits and services delivery policies, procedures, and interfaces

Associated Performance Measure(s): Veterans’ experience of VA

FY 2017 Milestones:

VA recognizes the importance of VCL as a life-saving resource for our Nation’s Veterans who find themselves at risk of suicide. Of all the Veterans we serve, we most want those individuals in crisis to know that dedicated, expert VA staff, many of whom are Veterans themselves, will be there when they are needed. Since its inception in July 2007, the VCL has answered over 3 million calls and initiated the dispatch of emergency services to callers in imminent crisis over 84,000 times. Since launching chat in 2009 and text services in November 2011, the VCL has answered nearly 359,000 and nearly 78,000 requests for chat and text services, respectively. In addition, staff has forwarded more than 504,000 referrals to local VA Suicide Prevention Coordinators on behalf of Veterans to ensure continuity of care with Veterans’ local VA providers. For FY 2016, more than 51,000 chats and 17,000 texts were answered by VCL responders. For FY 2017, nearly 54,000 chats and nearly 16,000 texts were answered by VCL responders. Emergency services were dispatched to over 12,000 callers in immediate crisis in FY 2016, and nearly 19,000 callers in immediate crisis in FY 2017. For FY 2016, nearly 87,000 referrals were made to local Suicide Prevention Coordinators

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for follow-up care and over 95,000 referrals were made in FY 2017.

Prior to the opening of the Atlanta call center in October 2016, VCL had a call rollover rate to backup call centers of more than 30 percent. Since January 2017, VCL's year-to-date rollover average is 1.04 percent. Overall, VCL performance exceeds the National Emergency Number Association service level standard of answering >95 percent of calls in less than 20 seconds. VCL continues to meet these metrics, despite overall call volume continuing to rise.

New to the VCL, VCL responder trainees complete a four-tier process that certifies they are adequately trained, competent, and cleared for answering calls independently. Tiers include classroom training, on-the-job training with the trainee paired with a preceptor/mentor, supervisor verification of competency through monitoring of a call answered by the trainee, and ongoing silent monitoring of calls for quality assurance.

VCL leadership have established the Executive Leadership Council (ELC), a governance structure responsible for documenting, tracking, and directing action of clinical quality performance measures.

Although the FY 2017 OIG asserts that the VCL faces significant operational challenges as it strives to carry out its mission, VCL has already successfully completed corrective actions to address and close three issues and corresponding recommendations identified by OIG. Recommendations 3 and 4, recommending collaboration between Member Services and Office of Suicide Prevention, as well as delineating clinical and administrative decision making, have been accepted for closure with the creation and implementation of a VCL directive outlining relationship and roles. OIG recommended that processes be in place to analyze performance and quality data separately from the Atlanta and Canandaigua call centers. This has been established as VCL

procedure and is reported monthly in VCL ELC meetings. Furthermore, through the clinical oversight provided to VCL by the Office of Mental Health and Suicide Prevention, VCL continues to make necessary corrective actions to address, by December 2017, the remaining issues and recommendations identified in the report.

4. LEADERSHIP AND QUALITY OF CARE

Hospital leaders oversee operations and guide the hospital on a day-to-day basis, ensuring that the hospital meets the needs of the patients it serves. By dedicating themselves to upholding the values and principles of the hospital's mission, leaders promote collaboration, communication, problem solving, conflict management, and ethical standards—practices that are essential to delivering safe and effective health care. While essential personnel are found in every staffing level within a hospital, instability or long-term vacancies of key leadership positions can directly impact the delivery of quality care.

VA's Program Response

Estimated Resolution Timeframe: The process of filling critical leadership positions in the health care arena is underway and will continue with the launch of the Healthcare Leadership Talent Institute (HLTI), the MyVA Critical Staffing Breakthrough Initiative, and the direct hiring provision of the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017.

Responsible Agency Official: Under Secretary for Health

Associated Strategic Goal: Manage and improve VA operations to deliver seamless and integrated support

Strategic Objective: Enhance productivity and improve efficiency of the provision of Veterans benefits and services

Associated Performance Measure(s):

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- Organization's leaders maintain high standards of honesty and integrity
- The average rating by patients of their recent VA hospitalization on a scale from 0 to 10 (inpatient)

FY 2017 Milestones:

The VA core values of Integrity, Commitment, Advocacy, Respect, and Excellence (I CARE) set the ethical tone across the entire VA organization. These core values define VA's identity, are the foundation of VA culture, and help guide the actions of staff across VA. Additionally, these core organizational values support VA's mission to provide the best care and services to Veterans, their families, and their beneficiaries.

The VHA follows the Standards of Ethical Conduct for Employees of the Executive Branch. Standards of ethical conduct are communicated through training in VA core values, government ethics and whistleblower rights and protection, and prohibited personnel practices, which are required annually and made available through VHA's Talent Management System. Additionally, the Office of General Counsel provides government ethics training and advice.

VHA is committed to ensuring equal employment opportunity (EEO), constructively resolving workplace disputes at the lowest possible level, and promoting diversity and inclusion to maintain a high-performing workforce in service to our Nation's Veterans. VHA will enforce all applicable federal EEO laws, executive orders, and management directives to ensure equal opportunity in the workplace for all VHA employees, applicants, and former employees. Managers will have adequate training in the management of a diverse work force, early and alternative conflict resolution, and essential communications skills. Facility Directors are responsible for designating management officials who may propose and decide actions for code of conduct

violations. Performance plans include elements that address ethics and adherence to policies and procedures.

Medical Center Directors (MCD) and other key hospital leaders provide oversight and guidance to clinical and administrative services to ensure patients' needs are served. On a daily basis, leaders review aggregate data, critical reports, and emerging clinical and administrative trends throughout the facility to ensure regulatory requirements are met and related issues are appropriately and effectively addressed. In addition to guiding long-term planning, leaders manage the ongoing process of anticipating, receiving, addressing, and monitoring internal and external reviews, and work with VISN and VHACO communications teams to provide clear, accurate, and consistent messaging to external media, Veterans, and their families regarding long-term goals and emergent daily issues.

Through efficient use of Town Halls, rounds, and routine meetings, facility leadership maintains consistent and open communication with facility personnel to collect, analyze, and prioritize key health care service issues. MCD manage conflict and resolve issues by collaborating with the VISNs, and with VHA congressional advisory offices to mediate, advocate for and resolve incoming congressional issues and priorities. Facility leadership advances VA and VHA initiatives through close coordination with offices across the Department and by engaging appropriate stakeholders within and across organizations as needed to support key operations projects, to include Veteran Service Organizations, which are key in ensuring interests are addressed and needs are met for optimal outcome for Veterans.

In March 2016, VHA launched the HLTI. The organization recognized a need for a more systematic approach – combining leadership development, assessment, coaching, and succession planning to create a long-term,

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comprehensive process for managing our succession pipeline. HLTl serves to identify, develop, and strategically manage the leadership talent across VA and continually grow an engaged performance-oriented workforce that delivers exceptional service experiences to our Nation's Veterans.

HLTI set about establishing an integrated system to identify, develop, and manage VA talent to meet the need for high-performing transformational leaders aligned with the VA mission and strategic direction. HLTl applies two main principles in preparing the leadership pipeline.

A deliberate focus on developmental opportunities that maximize the acquisition of leadership competencies through growth activities that are 70 percent experiential (e.g., details, assignments, committees), 20 percent exposure (e.g., coaching, mentoring, shadowing), and 10 percent education and training.

Implementing a comprehensive evaluation process to assess and share specific and direct feedback to individuals within the leadership pipeline, HLTl undertook the design and pilot testing of a talent management process to identify those employees with the background and drive to become successful MCDs, and to provide them with developmental experiences to prepare them for future leadership roles. In FY 2018, HLTl will begin applying the methodology to support succession planning for other key facility senior leadership team positions (Associate/Deputy Director, Chief of Staff, and Associate Director for Patient Care Services).

VHA has also made significant strides in raising fill rates for key leadership positions through the use of innovative recruiting strategies, streamlined hiring processes, and efforts to strengthen the leadership pipeline with qualified candidates. VHA re-engineered the recruitment process for filling its MCD positions. Under the

MyVA Critical Staffing Breakthrough Initiative, VHA partnered with the Corporate Senior Executive Management Office (CSEMO) to fill MCD positions through a national recruitment strategy by posting national vacancy announcements for multiple locations across the country and leveraging social media outlets and other venues to increase the public's awareness of these leadership roles. Under this national recruitment strategy, VHA instituted a corporate approach in making selections and obtaining approvals to ensure MCD positions are filled within 120 days from the vacancy. As of today, we are currently at a 90 percent fill rate for MCD positions.

Although VHA has made tremendous progress in streamlining the recruitment process, filling MCD positions is still a laborious and lengthy process. To address this impediment, VHA will leverage the direct hiring provision of the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017, which provides the VA Secretary flexibility to directly hire MCDs.

VHA will continue to utilize all resources such as the HLTl, CSEMO training programs, and other departmental training entities to ensure leadership have the tools to promote opportunities to train qualified candidates for key leadership positions.

In reference to the OIG report, *Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care (17-01846-316)*, the VA OCC implemented a medical documentation tool that simplifies the process of gathering and organizing all applicable medical history information and a complete up-to-date list of medications into one uniform document. The REFDOC tool compiles a package of documentation including a comprehensive medications list of outpatient and pain management meds dispensed by VA in last 12 months and current medications prescribed by non-VA sources that are recorded in the VA data warehouse. This complete package is

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automated and therefore assures complete information is transmitted to the non-VA provider.

In reference to the OIG report, *Evaluation of the Veterans Health Administration Veterans Crisis Line* (16-03985-181), VCL incorporated a new Customer Relationship Management system into the phone system so that call records are automatically populated with the phone number of the caller. VCL worked to update the policies and procedures for audio call recording and in the process of working with the OI&T to provide IT support. Member Services and the Office of Mental Health Operations establish a governance structure that is evident in the published VHA Directive 1503, "Operations of the Veterans Crisis Line Center," May 31, 2017. The recently published VHA Directive 1503, "Operations of the Veterans Crisis Line Center," presents the clear guidelines that were developed to delineate clinical and administrative decision making. VCL developed a process to review and ensure wait-time targets for call queuing and rollover are meeting predefined metrics.

In reference to the OIG report, *Interim Summary Report—Healthcare Inspection—Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC* (17-02644-202), an incident command center (ICC) was established to streamline medical supplies and logistics service processes, address staffing needs, and assess the overall environment of care. The ICC implemented a robust oversight process that identified and promptly addressed new supply or equipment shortages on a 24-hour basis, and included daily supply rounds in all patient areas by logistics and nursing staff, multidisciplinary Operating Room huddles, and timely review and action on issues brought forth to the ICC. VA also began the process of re-establishing an electronic management system, the Generic Inventory Package (GIP), at the facility that involved cataloging the Primary Inventory Point

area, Warehouse inventory, critical secondary (ICU, ED, OR, Dialysis) inventories, and noncritical primary and secondary inventory points, and then entering them into the GIP.

In reference to the OIG report, *Review of the Implementation of the Veterans Choice Program* (15-04673-333), VHA OCC executed initiatives and projects to build and improve capabilities for Veteran community care and to streamline processes for accessing care under the VCP. Improvements incorporated those specified in a succession of legislative amendments to the Choice Act and are helping to reduce the consult/referral life cycle timeframe. Various actions taken have included contract modifications; training; documentation of flow maps, standard operating procedures (SOP); creation of Fact Sheets and internal printed communication resources designed to keep the field apprised of all new developments; directives; a REFDOC tool; single booking pilot; and a consult toolbox and overview.

KEY RELATED LINKS:

Healthcare Inspection—Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care

8/1/2017 | 17-01846-316 | [Summary](#) /

Healthcare Inspection—Patient Deaths, Opioid Prescribing Practices, and Consult Management, VA Greater Los Angeles Healthcare System

5/23/2017 | 15-01669-246 | [Summary](#) /

Healthcare Inspection—Consult Management Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California

5/4/2017 | 15-04681-228 | [Summary](#) /

Interim Summary Report—Healthcare Inspection—Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC

4/12/2017 | 17-02644-202 | [Summary](#) /

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Healthcare Inspection—Opioid Prescribing Practice Concerns, VA Illiana Health Care System, Danville, Illinois

3/30/2017 | 16-00462-192 | [Summary](#) /

Healthcare Inspection—Evaluation of the Veterans Health Administration Veterans Crisis Line

3/20/2017 | 16-03985-181 | [Summary](#) /

Healthcare Inspection—Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana

3/10/2017 | 16-00621-175 | [Summary](#) /

OIG SUB-CHALLENGE #1B: ACCESS TO CARE (VHA)

Access to health care has been a recurring issue in VHA. For more than a decade, OIG, the Government Accountability Office, VA, and other organizations have issued numerous reports regarding issues with access to VA care including veteran wait times, scheduling practices, consult management, and Choice. Since the nationwide scandal on patient wait times in 2014, OIG has continued to identify problems with VHA's management of health care access. OIG reviews at VISN 6 and at least six other VA medical facilities—Colorado Springs, Houston, Oklahoma City, Phoenix, St. Louis, and Tampa—showed that VHA continues to experience significant issues with the reliability of veteran wait times, scheduling practices, consult management, and access to Choice.

VA's Program Response

Estimated Resolution Timeframe: 2019

Responsible Agency Official: Under Secretary for Health

Associated Strategic Goal: Manage and Improve VA operations to deliver seamless and integrated support

Strategic Objective: Enhance productivity and improve efficiency of the provision of Veterans benefits and services; Evolve VA IT capabilities

to meet emerging customer service/empowerment expectations of both VA customers and employees

Associated Performance Measure(s):

- Percent of primary care patients who respond "Always" and "Usually" regarding their ability to get an appointment for a routine checkup as soon as needed
- Percent of specialty care patients who respond "Always" and "Usually" regarding their ability to get an appointment for routine checkup as soon as needed
- Percent of primary care patients who respond "Always" and "Usually" regarding their ability to get an appointment for needed care right away
- Percent of specialty care patients who respond "Always" and "Usually" regarding their ability to get an appointment for needed care right away.

FY 2017 Milestones:

VA has undertaken many activities to ensure Veterans receive quality, timely access to health services.

The Office of Veteran Access to Care, a national-level office, was expanded in FY 2017. This department provides oversight and direction for policy and operations for optimization of Veterans' access to health care. This office is led by an executive-level Assistant Deputy Under Secretary for Health (ADUSH) for Access to Care who is a direct report to the Deputy Under Secretary for Health for Operation Management and also has a platform for interaction and feedback with the Secretary VA, Deputy Secretary VA, Under Secretary for Health, and Principal Deputy Under Secretary for Health.

VA's highest priority for access has been to ensure that Veterans with urgent needs receive timely care. As a part of this, VA worked to deliver same day services for care needed right away in Primary Care and Mental Health. As of December 31, 2016, SDS were achieved at all

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VAMCs and by the end of 2017, all CBOCs with Primary Care and Mental Health will have achieved SDS.

VA also worked to ensure that previously defined standardized processes to assure that new referrals to specialists are screened for urgent needs and scheduled timely is sustained throughout the organization. Back in Fiscal Year 2014, the average time it took for stat consults to be completed was 36 days. As of June FY 2017, the average time it took for completion of the stat consults was 1.7 days.

In support of the focus of stat consults, VA has continued a weekly national consult management call, whereby scheduling experts provide technical assistance to the field to ensure the timeliness of consult scheduling. The calls have become a driving force to deliver timely scheduling and completion of urgent consults. The call is well attended consistently with over 400 participants each week. Facilities across VA have also been working to reduce routine consult backlogs since June 2017.

To ensure the timely follow-up care for Veterans with urgent needs, in December 2016 VA implemented a process for providers to indicate priority for follow-up appointments to ensure that a Veteran's timely follow-up needs are met. Providers indicate a no-later-than date in the return to clinic order that signals the scheduler to arrange for the follow-up appointment by that provider-recommended date. Since implementation, as of August 14, 2017, 107,000 time-sensitive appointments have been completed across VA, and of those, about 90 percent have been completed no later than the provider-recommended date.

In order to reduce scheduling errors, VA focused on enhanced training and identifying warning signs that schedulers at a given facility were generating scheduling errors. VA recognized that its scheduler training in the past was not effective. In December 2016, based upon strong practices, VA commenced

systemwide mandatory face-to-face training of all schedulers. This included hands-on supervised practice scheduling sessions. No newly hired scheduler may commence scheduling Veterans until after they successfully pass this two-week training. To date, 100 percent of the approximately 20,000 Medical Support Assistants scheduling across the country in our VA health care system clinics had successfully completed this training program. Additionally, over 4,000 staff including clinicians completed training on the latest scheduling requirements as identified by VA's updated scheduling directive. Additionally, a mandatory standardized Supervisory Audit Tool was implemented June 1, 2017 in order to ensure that audits are completed on every scheduler. These audit results will be used by Facility, VISN, and national leadership to ensure compliance and to assist with identifying opportunities for improvement.

VA has also worked to strengthen its Clinic Practice Management Program at each VA health care system based upon private sector and DoD strong practices. A critical function of this program is to monitor data and oversee the timeliness and accuracy of Veteran appointments. Each VA system has at least one Group Practice Manager as well as a Clinic Practice Management team comprised of clinical and administrative leadership from Primary Care, Mental Health, and Medical and Surgical Specialties. Additionally, a user friendly Clinic Practice Management dashboard was updated this past year based upon feedback from the field; this dashboard can be utilized by the Group Practice Managers as well as facility clinical and administrative leadership to monitor clinic activities and identify opportunities to improve. The dashboard includes new scheduling performance data down to the level of an individual scheduler. Also, weekly Community of Practice Calls are attended by an average of 200 employees.

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To hold ourselves accountable to the community we serve and to empower veterans to make informed decisions about their health care, VA released a simplified tool in April, www.accesstocare.va.gov, to be transparent about our performance, while providing the meaningful data Veterans need. Veterans, their families, and caregivers can now easily use data related to how long patients are waiting to be seen at VA facilities in their area, how Veterans describe their experiences scheduling primary and specialty care, options available for care needed right away and information about the quality of health care delivered at every medical center.

Veterans Scheduling Enhancement is currently being implemented at all facilities within VA. At

the time of this report, over half of our medical centers have started using this system to schedule patients for their appointments. This system will make scheduling simpler and reduce scheduling errors. Training of schedulers and implementation is nearing completion.

Some examples of the progress made with performance in VA are as follows. VHA Consumer Assessment of Health Providers and System patient satisfaction scores have increased in all domains during the current year when compared to FY 2016. The greatest increase has been in the “care needed right away” category domains.

	FY 2016	FY 17 thru March
Primary Care Routine Care	83.6%	84.2% (+0.6%)
Primary Care Needed Right Away	72.4%	74.2% (+1.8%)
Specialty Care Routine Care	82.2%	83.3% (+1.1)
Specialty Care Needed Right Away	72.4%	73.8% (+1.4%)

Overall VA completed 58 million appointments within VA during FY 2016. This was 12,000 more appointments each business day when compared to where we were during FY 2014. In FY 2016, 22 percent of the appointments completed in VA were completed the same day the patient requested the appointment. For telehealth, 12 percent of Veterans receiving care from VA last year obtained 2.17 million telehealth appointments. By the end of 2017, 8 Primary Care hubs and 10 Mental Health hubs will be fully operational to deliver telehealth to spoke sites where provider shortages exist. Additionally, many VISNs have or are in the process of setting up their own hubs. VA is also employing Video Connect, a simplified tool for telehealth, where secure appointments occur using a Veteran’s smart phone, I-Pad, or desktop computer. VA has focused on

improving productivity. For this, clinical productivity measured as total work relative value units/clinical FTEE increased by 9 percent from FY 2014 to April 15, 2017.

Throughout FY 2016 and to present day in FY 2017, the VHA OCC executed initiatives and projects to build and improve capabilities for Veterans’ community care and to streamline processes for accessing care under the VCP. Improvements incorporated those specified in a succession of legislative amendments to the Choice Act and are helping to reduce the consult/referral life cycle timeframe. Various actions taken have included contract modifications; training; new and enhanced SOP; creation of Fact Sheets and internal printed communication resources designed to keep the field apprised of all new

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developments; directives; a REFDOC tool; single booking pilot; single booking processes; and the implementation of the OneConsult and consult toolbox.

The OCC modified current VCP contracts to simplify the referral process, increase continuity of care, decrease Secondary Authorization Requests workload, and resolve provider billing and payment issues. These contract modifications give VA the ability to include Episode of Care changes. Health Net/TriWest can update the duration of care approved by VA seven days earlier and up to 60 days later than the Episode of Care, and to lead adjudication actions for aged Secondary Authorization Requests uploaded to VA portals prior to January 27, 2017.

Contracts now align more closely with the Health Benefits Package (Title 38 Code of Federal Regulations 17.38). Veterans will be able to schedule their own appointments, while VA coordinates referrals directly with community care providers for some services. For providers, improved processes promote more timely payment while maximizing industry health information exchange systems, allowing providers to send medical documentation directly to VA.

Other contract enhancements include network adequacy, provider fraud, high-performing network, eligibility and enrollment, customer service, and increased transparency and quality monitoring. The OCC added Tele-Mental Health to covered services under the Choice contracts. Phase I of this program deployed in November 2016. As of April 12, 2017, the preliminary results indicated high Veteran satisfaction and high rates of return appointments. Tele-Mental for community care has also rolled out at 30 VA sites.

Other Program enhancements include the Update of Construction Authorization and Choice Improvement Act – Unusual or Excessive Burden Determination (UEXB).

Under this amendment, the Secretary has discretion to define “other factors” creating the usual or excessive burden in travel and basis for VCP eligibility. UEXB no longer restricts authorization to previously identified specialty services. Effective February 24, 2017, VA clinicians may decide whether a Veteran is eligible to use VCP under the “other factors” provision of UEXB.

As part of the various actions taken to remedy issues specific to scheduling and care coordination, the OCC modified and enhanced VA Form 10-0386, VHA Choice Approval for Medical Care. The enhancements include making the Type of Specialist field completion mandatory by VA (helping to alleviate miscommunication and misdirection to inappropriate specialties), new date field format to prevent text entry/bypass, and improvements to descriptions of service. The enhancements to VA Form 10-0386 also included added contact information for Veterans, ensuring the most current contact information available when attempting to schedule care.

To further reduce scheduling delays, the OCC implemented the Choice Category of Care Withhold process allowing VA to expand the use of Veterans Choice Provider Agreements. Previously, VA limited provider agreements to services not offered in the contract, or referrals returned for specific reason for services that are in the Choice contract.

Through this process, VAMCs now identify referrals repeatedly returned for specific care categories and use other means to outsource the services, and use the information gathered on returned referrals to work with the Contractors on network development. The OCC communicates returned referral data to the VISN/VAMCs monthly, so that they may assess impact on their geographic areas. VA also communicates high return rate category lists to the contractor with a notice that the facility will not send the specific care category for the following month based on high return rates.

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The single booking process will be fully implemented with the OneConsult and consult tool box rollout in the September timeframe. Single booking streamlines managing appointment requests greater than 30 days for eligible Veterans who seeking care outside the VA. Per the Enhancements to the VCP Referral Processes Memorandum, local Community Care offices must implement Single Booking by June 2017. Community Care leadership is closely monitoring the implementation of Single Booking. As of August 2017, 93 VAMCs fully implemented single booking, 23 VAMCs have partially implemented, and 24 VAMCs have not implemented the process.

In addition, VA has taken steps to reduce administrative burdens, enhance guidance, and speed provider payments. VA modified the contract to decouple medical documentation receipt from claims payment speeding up the provider payment process.

The mass mailing to community providers regarding Electronic Data Interchange submissions, along with other provider billing guidance, increased available resources to enhance the providers' ability to receive a timelier payment.

Over the last year, the VCP provider network has continued to grow. Over the last year, there has been an increase nationally in the number of providers in Health Net and TriWest's respective provider networks. As of December 31, 2016, the Patient Centered Community Care (PC3)/Choice Provider Network has grown by 63 percent compared to December 2015. Please note that Health Net covers 13 VISNs while TriWest only serves 8.

VA acknowledges that there have been performance issues with the Choice contractors, but they have implemented improvements through VA contract modifications and VA has the controls in place to continue to improve upon contractor oversight. VHA Choice modifications enacted

during FY 2016 and FY 2017 prompted changes regarding the expected specific actions and specific timing for routine and urgent appointments. Choice contract modifications included:

- Requires the contractor to schedule urgent authorizations within two business days after the creation of the authorization. If the contractor cannot schedule the care within two business days, the authorization shall be returned on the third business day.
- Enhances the routine authorization return process, requiring the contractor to schedule routine care within 5 business days after the creation of the authorization for 95 percent of these authorizations, with no more than 5 percent being able to be appointed up to 10 business days. The contractor will return all authorizations not appointed by the 10th business day. This enhancement requires the contractors to begin returning authorizations based on the timing limits placed on scheduling appointments.

Performance monitoring is an ongoing activity. VHA aggressively pursued improvements in 2017 that would give the VHA more timely, accurate, and complete visibility into contractor performance.

VHA and the Choice Contractors conduct quarterly Performance Management Reviews, at which time both parties review monthly performance reports. The formal reviews are a key part of the controls that VHA established to ensure contractor performance and compliance with contract standards and to discuss issues and opportunities for further improvements. During 2016 and to present day, these reviews covered appointment and return authorization performance as well as confirmed the accuracy and timeliness of performance data received from the contractors. VHA sends Letters of Correction for areas failing to meet performance standards.

Weekly discussions between VHA and the contractors, called "Round Tables," which

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began in September 2016, as well as VHA internally staffed “portfolio” teams initiated in early 2016 have surfaced improvements for referral, appointing, and care coordination processes and data. The three major categories that these discussions have focused on relate to (1) policy and process enhancements; (2) scaling of existing technological efficiency enhancements to address data collection, reporting, and sharing of information; and (3) recommended contract enhancements for third-party administrator performance improvement.

Since the Choice contract origination in 2014, VA has worked to design and improve the monthly contractor performance reporting format and its related data collection activities. VA expanded automation activities to support data contractor quality, validation, and verification. Additional software was implemented by the contractors to assist with identifying data inaccuracies before submission to VA, to ensure the complete data set needed for performance reporting, and to enable greater reporting consistency between the two Choice contractors. This “Data Tracker” Tool incorporates automated data checks for each performance report field and includes filters to automatically calculate and report performance levels. The tool has improved the data collection process and overall third-party administrator data accuracy and integrity. It has improved the consistency of reporting. VHA recognizes that continuing changes in data requirements present data reporting challenges to the Contractors in the past. In FY 2017, there have been no further amendments to the data requirements, and from that time forward VHA has made a concentrated effort not to alter reporting requirements ad-hoc and only group many changes together and do them all at once.

In reference to the OIG VISN-specific report, *Healthcare Inspection – Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6* (16-02618-424), VISN 6

completed the following actions in FY 2017. The facility requested closure on one recommendation. The facility implemented several corrective actions to address the OIG recommendations, including strengthened controls over access to health care and consult management across all facilities. The VISN educated schedulers on Consult Processes and Procedures, and audited scheduler performance biannually with use of the Supervisory Appointment tool. VISN 6 is in the process of reviewing staffing levels to determine if they are a contributing factor in addressing the requirements of the Choice program. The OCC modified the Choice contract and the Under Secretary for Health completed analyses of third-party administrator return authorization timeliness and appointment scheduling. Overall improvement in performance was noted.

In reference to the OIG site-specific report, *Healthcare Inspection – Review of Alleged Improper Non-VA Community Care Consult Practices at the Ralph H. Johnson VA Medical Center, Charleston, South Carolina* (14-02890-352), the report is closed and has no open recommendations. The facility took the following actions in FY 2017: completed a review of the care of one patient internally and externally. The review found that the procedures and time lines associated with processing of the consult did not change the outcome for the patient. The facility’s Non-VA Coordinated Care Service now tracks all consults, including those with no action within seven days, on a daily basis. This information is provided to the leadership team for review and action as needed.

In reference to the OIG site-specific report, *Healthcare Inspection – Review of Alleged Wait-Time Manipulation at the Southern Arizona VA Health Care System* (14-02890-72), the site requested closure on all recommendations. The facility took the following actions in FY 2017: reviewed the

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training records of all schedulers for compliance with VHA mandatory training requirements for scheduling. All schedulers were educated on the new VHA scheduling policy. The Compliance Office performed biweekly monitors of scheduling practices and reported outliers to the section chief for remediation and training. Leadership appointed an Administrative Board of Inquiry to determine how the Business Service Line officials created and used training materials which did not comply with VHA scheduling policy.

In reference to the OIG site-specific report, *Healthcare Inspection – Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System* (15-04672-342), the site took the following actions in FY 2017: completed review of the patients identified in the OIG report to ensure follow-up with appropriate services; implemented new software to allow automated data entry of vascular study results into the EHR; implemented a daily review of all vascular lab studies by a vascular surgeon; implemented a process to review open community care

consults older than 120 days; supervisors review the report weekly; scheduling staff in the Choice-First program have been retrained to ensure consults are forwarded to Choice-First to the selected vendor timely.

KEY RELATED LINKS:

Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6 3/2/2017 | 16-02618-424 | [Summary](#) |

Review of the Implementation of the Veterans Choice Program 1/30/2017 | 15-04673-333 | [Summary](#) |

Review of Alleged Improper Non-VA Community Care Consult Practices at the Ralph H. Johnson VA Medical Center, Charleston, South Carolina 12/20/2016 | 14-02890-352 | [Summary](#) |

Review of Alleged Wait-Time Manipulation at the Southern Arizona VA Health Care System 11/9/2016 | 14-02890-72 | [Summary](#) |

Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System 10/4/2016 | 15-04672-342 | [Summary](#) |

OIG CHALLENGE #2: BENEFITS DELIVERY

STRATEGIC OVERVIEW

Delivering timely and accurate benefits is central to VA's mission. The VBA is responsible for oversight of the nationwide network of VA Regional Offices (VARO) that administer a range of veterans benefits programs, including compensation, pension, education, home loan guaranty, VR&E, and life insurance. These programs are estimated to pay out over \$107 billion in claims to veterans and their beneficiaries in FY 2018.

OIG conducts inspections of all 56 VAROs and the Veterans Service Center (VSC) in Cheyenne, Wyoming, generally on a three-year cycle to examine the accuracy of claims processing and the management of VSC operational activities. These inspections

address the processing of high-risk claims such as residual disabilities related to TBI and special monthly compensation (SMC) claims and related ancillary benefits payments reserved for veterans with quality-of-life issues due to severe disabilities related to military service.

In FY 2017, OIG inspected 16 VAROs—initiating the third review cycle of VBA's 57 claims processing offices. During FY 2017, OIG also reported the results of reviews related to VBA programs, operations, and complaints received through OIG's Hotline Division. The results of these reviews demonstrate that additional improvement is necessary to ensure

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the accuracy of processed claims and controls over claims processing are adequate.

OIG SUB-CHALLENGE

#2A: IMPROVING THE ACCURACY AND TIMELINESS OF CLAIMS DECISIONS (VBA)

OIG continues to report the need for enhanced policies and procedures, training, oversight, quality reviews, and other management controls to improve the timeliness and accuracy of claims decisions. Claims processing that lacks compliance with VBA procedures could increase the risk of improper benefits payments to veterans and their families. During inspections, OIG sampled claims with certain medical disabilities considered to be at higher risk of processing errors, thus results do not necessarily represent the overall accuracy of disability claims processing at the VAROs. In FY 2017, OIG reported on the performance of 16 VAROs in the following areas:

- Residual disabilities related to TBI
- SMC and related ancillary benefits
- Benefits reductions
- Systems compliance
- Special controlled correspondence.

Overall, OIG reviews disclosed deficiencies in SMC, benefits reductions, and special controlled correspondence. For example, 21 percent of the total 388 disability claims statistically selected from VAROs that related to SMC claims contained errors. The errors resulted in more than \$684,000 in improper benefits payments. Also, VARO staff did not correctly process or complete 39 percent of 405 proposed benefits reductions cases, resulting in approximately \$860,000 in improper benefits payments. OIG also determined VARO staff used inaccurate or incomplete claim and claimant information in 53 percent of 480 records in the electronic systems at the time of claim establishment.

VA Program Response

Estimated Resolution Timeframe: 2017

Responsible Agency Official: Under Secretary for Benefits

Associated Strategic Goal: Empower Veterans to improve their well-being

Strategic Objective: Increase customer satisfaction through improvements in benefits and services delivery policies, procedures, and interfaces

Associated Performance Measure(s):

- Percentage of VA Disability Rating Claims pending more than 125 days
- Percentage of Disability Compensation Rating Claims inventory pending more than 125 days
- National Accuracy Rate – Disability Compensation Rating Claims
- National Accuracy Rate – Disability Compensation Rating Claims – Issue Based
- Percent of Disability Compensation Claims received virtually/electronically
- Percentage of Dependency and Indemnity Compensation Claims inventory pending more than 125 days
- Non-Rating Claims, Compensation Average Days Pending
- Non-Rating Claims, Compensation Average Days to Complete
- Dependency Claims Processing: Inventory (Claims Pending)
- Dependency Claims Processing: Timeliness (Month-to-Date Average Days to Complete as of the last month of the year)
- Compensation: Overall customer satisfaction index score (out of 1,000)
- Appeals Processing - Notice of Disagreement (NOD) Pending Inventory
- Appeals Processing - NODs Average Days Pending
- Appeals Processing - Substantive Appeals to the Board (Form 9) Pending Inventory

The VBA is committed to providing Veterans with the care and services they have earned and deserve. As of July 31, 2017, the average age of pending compensation claims was 97.7 days. For the eighth consecutive year, VBA has

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completed over 1 million disability claims and anticipates completing a record number of claims in FY 2017. Although VBA focused on its priority goal to eliminate the disability rating claims backlog for Veterans who have waited the longest, and is achieving record-breaking levels of production, it continues to remain focused on nonrating claims.

VBA provides oversight and prioritization of proposed rating reduction cases at the national level. As of April 9, 2017, all ROs receive a daily distribution of actionable due process work that is priority homeless, priority terminally ill, part of VBA's oldest pending claims, etc. Nationally, ROs are held to a standard that all work must be completed on a claim that is distributed to them within five days. Regional and District Office leadership, as well as the Office of Field Operations, routinely monitor stations' performance related to the five-day Time In Queue standard. Since the National Work Queue (NWQ) began managing the distribution of End Product (EP) 600s (due process EPs), timeliness of these claims has improved by 30 days. In FY 2017, VBA established Non-Rating Resource teams at 12 ROs. NWQ routes primarily special project work to these teams. Currently, the teams are focused on SMC, drill pay, Federal Bureau of Prison matching, and character of discharge. If there is no actionable work available for the special project teams, NWQ routes additional nonrating priorities (e.g., dependency) to those teams. Since their establishment in April 2017, VBA has seen a 57 percent reduction in this nonrating inventory.

VBA also developed and implemented new performance standards for Veterans Service Representatives and Rating Veterans Service Representatives (RVSRs) to provide better support for VA's national workload strategy. The updated standards shift from a focus on a singular final production target, to an emphasis on actions that promote improved efficiency

throughout the entire claims development process.

VBA's Rules-Based Processing System (RBPS) has enabled it to automate adjustments for adding and removing dependents. As of July 31, 2017, 72 percent of the dependency claims submitted through RBPS were automatically processed and Veterans' award adjustments were completed within one day. Claims that do not meet the criteria for automatic processing or claims that cannot be validated through the automated rules-based decision criteria are routed for manual processing. VBA will continue to focus efforts on completing the oldest dependency claims while continuing to reduce overall inventory. In addition, distribution of dependency claims through NWQ will increase, further adding claims processing efficiencies.

VA's modernization efforts focus on improving its performance to better serve Veterans, their families, caregivers, and Survivors while being good stewards of taxpayer dollars. To continue improving disability claim processing, VBA began implementing a program called Decision Ready Claims (DRC) in May 2017, with national implementation completed by September 1, 2017. The DRC Program is an expedited claims submission option available to Veterans who have elected accredited VSOs to assist them with preparing and submitting their disability claims. Under the DRC Program, VSOs work with Veterans to ensure all supporting evidence is included with the claim at the time of submission. This program will also enhance partnerships with VSOs by improving access and capabilities to assist with gathering all required evidence and information to accelerate claims decisions. Claims submitted in the DRC Program will result in a claims decision within 30 days of submission to VA.

The DRC Program was initially implemented on May 1, 2017, at the St. Paul RO, and all ROs will operate under this claims processing model by September 2017. Currently, 40 ROs have received the DRC training and have begun

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receiving and processing DRCs. The remaining 16 ROs are scheduled to complete training by September 1, 2017, at which time they will begin receiving and processing DRCs. As of August 18, 2017, there have been 151 DRC submissions with 118 completed in an average of 8.7 days.

VBA completed deployment of the Centralized Mail Program to all ROs in 2015, and to the Pension Management Centers (PMC) in FY 2016. Since deployment, VBA has gained proficiency in electronic mail processing and is now able to provide assistance with virtual mail processing, as needed across ROs. In FY 2017, VBA focused on File Bank Extraction (FBE), an effort to rapidly extract all inactive paper claims from ROs on a national level while having the Office of Business Process Integration and its Veterans Claims Intake Program assume logistical tracking control at the point of origin. FBE is a continuation of VBA's transformation and transition from paper-based to electronic claims processing. FBE also assists in refocusing on the mission-critical work, such as CM, by alleviating the burden of paper from ROs.

The benefits of FBE are that it ensures claim materials are in the Veterans Benefits Management System (VBMS) on day 1 of future claims, it reduces the overall amount of space dedicated to storage, and it fully leverages document conversion capacity, directly supporting VBA's strategic transformation goal to become completely paperless.

VBA also released an updated higher level SMC training course for RVSRs, Rating Quality Review Specialists, and Decision Review Officers. In addition, VBA updated training materials and released a video on system compliance for VSC personnel.

In FY 2017, VBA deployed a new Quality Management System (QMS), a platform that allows VBA quality control to be performed in

one system. This means full integration of all checklist-based quality reviews such as Statistical and Technical Accuracy Reports, Individual Quality Reviews, In-Process Reviews, pension, and appeals. Furthermore, it positions VBA to integrate and use our systems more efficiently by moving quality into a national processing scope versus localized reviews. Additionally, QMS is able to support an entire quality cycle in one system from claim selection, quality review, peer and quality review team performance reviews, error corrections, and reconsiderations. In doing so, this allows a more permanent audit trail for every step in the quality review process, which furthers our commitment to transparency.

As of July 31, 2017, nationally, claim-based accuracy was at 86.2 percent (+/- 0.8 percent margin of error), and issue-based accuracy remained high at 94.5 percent (+/- 0.3 percent margin of error). Issue-based accuracy is measured by assessing each medical disability decision within a rating-related compensation claim. Each issue a Veteran raises must go through the same series of discrete tasks, such as VBA providing duty to assist, gathering evidence, and making the decision. VBA may err on one aspect of the claim for a medical issue, but correctly process the remaining issues within the claim. Hence, the outcome of claim-based accuracy, which considers a claim to be processed either correctly or incorrectly, is not beneficial for analysis or training purposes and presents a misleading picture of VBA's accuracy. Issue-based accuracy provides VBA the opportunity to precisely target medical issues where adjudication is more error-prone and additional training is needed.

During the 1990s, VBA received an increased volume of C&P claims, related to disability compensation, which created a need for an increase in the number of examinations required to process claims. As a result, legislation was enacted authorizing the SECVA to utilize contract examinations through VBA as

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a means to address the need for increased exam capacity. The VBA Contract Exam Program was implemented in 1998 to supplement the C&P examination program traditionally covered by the VHA. Over time, this Congressionally mandated pilot expanded and in 2016, the Secretary of VA was provided authority to expand this program to all ROs. VBA created the Contract Exam Program Office to oversee all elements of the process as it related to acquisition, program operations, and vendor quality.

The original Mandatory Disability Examination (MDE) contract award was protested and after several legal actions, the Court of Federal Claims was given jurisdiction over the issue in January 2017. On June 12, 2017, the Court of Federal Claims resolved the pending litigation regarding VBA contract exams and found in favor of VA. As a result, the contract award assignments were upheld and the new vendor ramp-up period began on June 28, 2017. Vendors are afforded a 90-day ramp-up period to establish a provider network, employees, and building space. The vendor ramp-up period is in place until September 26, 2017.

The MDE vendor performance is assessed quarterly and is determined by evaluations of the vendors' timeliness and quality of work completed. The vendor timeliness standard requires them to complete all Outside Continental U.S. disability examinations in an average of 20 days from the date the request is submitted to the date the vendor uploads the results into VBMS. The vendors' performance standard is 10 days faster than VHA's standard, thus decreasing claims processing time. The vendors are also required to maintain a minimum of 92 percent accuracy. The quality measure is based on a sample size of all work completed by each vendor in each district quarterly with a 95 percent confidence level.

VBA uses the MDE contract as a supplement to the C&P examination process. VHA capacity is used before VBA vendors are harnessed to

complete examinations. This process requires constant communication with VHA to discuss issues related to capacity and timeliness. VBA uses VHA data through the Examination Request Routing Assistant tool to help claims processors across the country submit examination requests based on the availability of VHA facilities nationwide.

The current VA appeals process is a complex, nonlinear process that is unlike standard appeal processes found in other administrative or judicial systems. It has multiple steps, most of which occur at VBA as the agency of original jurisdiction. If a Veteran is not satisfied with the initial VBA determination, he or she may continue the appeal to the Board of Veterans' Appeals (Board) for a final agency decision. A feature of the current VA appeals process is an open record that allows appellants to submit new evidence and/or make new arguments at any point in the appeals process. Additionally, the statutory duty to assist requires VA to gather further evidence on the Veteran's behalf. When new arguments are presented and evidence is obtained, VA generally must re-adjudicate the appeal, which lengthens the timeline for final appellate resolution. VA's appeals process essentially contains another claims process, as new contentions are added as part of the appeal, rather than initiated as a new claim, which delays a final outcome for Veterans.

Modernizing the appeals process through legislative reform and other people, process, and technology is one of VA's top priorities. Accordingly, as part of an effort to streamline and improve appeals processing and demonstrate its commitment to appeals reform, in January 2017, VBA realigned its administrative appeals program under the Appeals Management Office (AMO). This realignment identified a single accountable official within VBA, the AMO Director, who is responsible for overseeing VBA's appeals. This allows VBA to increase oversight and

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management attention in its appeals program, while also allowing greater focus on the complex and challenging nonappeals workload and policy issues that arise in VBA's business lines.

Following the creation of the AMO, appeals resources were streamlined to facilitate consistent benefit delivery and higher customer satisfaction. By the end of July 2017, VBA's appeals production was 13.5 percent above the FY 2017 goal and was 24.1 percent above production at the same point in FY 2016. The substantive appeal (VA Form 9) inventory was reduced by 3.1 percent, to approximately 41,000. Moreover, VBA decreased its appeals inventory by 9 percent to 312,000 and its remand inventory by 13.4 percent to 29,000 since the beginning of FY 2017.

VA acknowledges that realignment of appeals resources alone cannot fix the broken appeals process. Accordingly, since early 2016, VA has worked very closely with VSOs and other stakeholders to design a new comprehensive legal framework for appeals.

On August 23, 2017, the President signed the new framework into law as the Veterans Appeals Improvement and Modernization Act of 2017. Under the new law, VA has 18 months to implement a new appeals process that eliminates the complexity and inefficient churning of appeals that was inherent in the old process, and provides Veterans with multiple options for early resolution of their disagreement with VA's benefits claim decisions.

Once the appeals reform legislation goes into effect, following the proposed 18-month implementation period, VA plans to evaluate and report on the new process by examining wait times for Veterans with decision processing times meeting timeliness goal averages of 125 days in the higher-level review lane, 125 days in the supplemental claims lane, and 365 days for appeals to the Board in which

there is no request for a hearing and no additional evidence is being submitted. VA plans to take a Veteran-centric approach to measuring the success of the new appeals process. VA will measure average Veteran wait times in the new process as one indicator of success. In addition, VA is working, internally, to determine the best way to measure Veteran satisfaction with the new process. VA will also continue to respond to congressional tracking reports, requests for information, and questions for the record from Congress, including any questions regarding the extent to which VA is improving Veterans' experience in its appeals process. Internally, VA also plans to compare the new process to the current appeals process using various performance metrics, such as days to resolve an appeal.

KEY RELATED LINKS:

Inspection of the VA Regional Office Philadelphia, Pennsylvania
8/24/2017 | 17-01276-300 | [Summary](#) /

Inspection of the VA Regional Office Louisville, Kentucky
8/23/2017 | 17-00394-298 | [Summary](#) /

Inspection of the VA Regional Office Indianapolis, Indiana
8/3/2017 | 16-04918-263 | [Summary](#) /

Inspection of the VA Regional Office Seattle, Washington
8/3/2017 | 16-04764-266 | [Summary](#) /

Inspection of the VA Regional Office Boise, Idaho
6/21/2017 | 16-04762-232 | [Summary](#) /

OIG SUB-CHALLENGE

#2B: IMPROVING DATA INTEGRITY, INTERNAL CONTROLS, AND MANAGEMENT WITHIN VAROS (VBA)

OIG assessed the merits of OIG Hotline allegations regarding the manipulation of data and lack of controls over claims processing. In several instances, OIG substantiated the allegations. Specifically, OIG reviews documented that VARO claims processors improperly removed controls which resulted in the improper termination of veterans' claims without the appropriate review and processing. OIG also determined that claims processors assigned incorrect effective dates when processing claims associated with "intent to file" (ITF) submissions. An ITF provides claimants the opportunity to submit minimal information related to their claim for benefits and allows up to one year for the claimant to provide additional information and evidence necessary to complete the claim. If benefits are subsequently established, VA may use the date the VARO received the ITF as the basis for an earlier effective date for benefits payments. However, VARO staff did not always assign the correct effective dates when they received an ITF. In addition, OIG determined opportunities existed to improve appeals workload management and processing timeliness. These opportunities included preventing periods of inactivity in which pending appeals were not being processed and errors that delayed appeals processing such as prematurely closing appeals.

VA Program Response

Estimated Resolution Timeframe: 2017

Responsible Agency Official: Under Secretary for Benefits

Associated Strategic Goal: Empower Veterans to improve their well-being

Strategic Objective: Increase customer satisfaction through improvements in benefits

and services delivery policies, procedures, and interfaces

Associated Performance Measures:

- Percentage of VA Disability Rating Claims pending more than 125 days
- Percentage of Disability Compensation Rating Claims inventory pending more than 125 days
- National Accuracy Rate – Disability Compensation Rating Claims
- National Accuracy Rate – Disability Compensation Rating Claims – Issue Based
- Percent of Disability Compensation Claims received virtually/electronically
- Percentage of Dependency and Indemnity Compensation Claims inventory pending more than 125 days
- Non-Rating Claims, Compensation Average Days Pending
- Non-Rating Claims, Compensation Average Days to Complete
- Dependency Claims Processing: Inventory (Claims Pending)
- Dependency Claims Processing: Timeliness (Month-to-Date Average Days to Complete as of the last month of the year)
- Compensation: Overall customer satisfaction index score (out of 1,000)

VBA takes seriously the issues OIG raised, has taken action to address them, and will continue to do so until they are resolved. VBA manages all rating claims and most nonrating claims from a national level through NWQ. ROs are also held to timeliness and quality standards.

The issue related to workload controls on EP 930s was specific to the San Juan RO, which was corrected locally through additional training and a comprehensive review of the 722 EP 930s that were processed during that time.

In July 2016, VBA issued final guidance on identifying and processing ITF claim filings.

On August 23, 2017, the President signed into law the Veterans Appeals Improvement and Modernization Act of 2017. Under the new law, VA has 18 months to implement a new appeals framework that eliminates the complexity and

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inefficient churning of appeals that was inherent in the old process, and provides Veterans with multiple options for early resolution of their disagreement with VA's benefits claim decisions. Once the appeals reform legislation goes into effect, following the 18-month implementation period, VA plans to evaluate and report on the new process by examining wait times for Veterans with decision processing times meeting timeliness goal averages of 125 days in the higher-level review lane, 125 days for the supplemental claims lane, and 365 days in the Board's nonhearing option lane.

In addition to Veteran wait times, VA plans to measure success of the new appeals process with the results from customer satisfaction surveys. VA believes that wait times and results from customer satisfaction surveys are the most appropriate, Veteran-centric metrics to capture success of the new process and to compare it

to the legacy process. VA will also continue to respond to Congressional tracking reports, requests for information, and questions for the record from Congress, including any questions regarding the extent to which VA is improving Veterans' experience in its appeals process. Internally, VA also plans to compare the new appeals process to the current appeals process using various performance metrics, such as days to resolve an appeal.

KEY RELATED LINKS:

Review of Alleged Removal of Workload Controls at the VA Regional Office in San Juan, Puerto Rico

5/24/2017 | 15-05235-200 | [Summary](#) |

Review of Alleged Use of Incorrect Effective Dates at VBA's VA Regional Office in Chicago, Illinois

3/31/2017 | 16-02806-182 | [Summary](#) |

OIG CHALLENGE #3: FINANCIAL MANAGEMENT

STRATEGIC OVERVIEW

Sound financial management represents not only the best use of limited public resources, but also the ability to collect, analyze, and report reliable data on which resource use and allocation decisions depend. OIG's oversight assists VA in identifying opportunities to improve the quality of VA's financial information, systems, and assets. Each year, OIG conducts mandatory reviews of VA's compliance with the Improper Payments Elimination and Recovery Act (IPERA) and the CFO Act, which requires an audit of VA's CFS. Further, OIG performs additional audits and reviews of other programs and activities which assess VA's management of appropriated funds.

Although VA has received an unmodified or "clean" opinion on its CFS from OIG's contracted auditors, VA has continuously faced challenges in achieving those results. A clean

opinion means the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States. However, OIG's independent auditors found several material control weaknesses and deficiencies. Also, the IPERA review disclosed financial-related issues the Department needs to address. Addressing these and other issues related to financial systems, information, and asset management would promote improved stewardship of the public resources entrusted for VA's use.

OIG SUB-CHALLENGE #3A: COMPLIANCE WITH IPERA (OM, VHA, VBA, AND OALC)

OIG conducted this mandatory review to determine whether VA complied with IPERA for FY 2016. VA reported improper payment estimates totaling approximately \$5.5 billion in its FY 2016 AFR. VA did not comply with two of

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six requirements that constitute compliance according to the OMB. Specifically, VA did not:

- Report a gross improper payment rate of less than 10 percent for each program and activity for which an improper payment estimate was published in the FY 2016 AFR. Two VA programs - VA Community Care and Purchased Long Term Services and Support - exceeded 10 percent.
- Meet annual reduction targets for the following six programs: VA Community Care, Purchased Long-Term Services and Support, Beneficiary Travel, Civilian Health and Medical Program of the VA (CHAMPVA), State Home Per Diem Grants, and Supplies and Materials.

VA met four of the six IPERA requirements for FY 2016 by publishing the AFR, performing risk assessments, publishing improper payment estimates, and providing information on corrective action plans. Although VA published improper payment estimates as required, OIG determined estimates for the Supplies and Materials Program and the Post 9/11 G.I. Bill Program were not reliable because of weaknesses in sample evaluation procedures. OIG also noted further improvements VA could make in estimating improper payments for two programs and in reducing improper payments for another program that resulted from a program design issue.

VA Program Response

Estimated Resolution Timeframe: 2020

Responsible Agency Official: Acting Assistant Secretary for Management and Acting CFO (Lead), Acting Under Secretary for Health, and Acting Under Secretary for Benefits, Principal Executive Director of Office of Acquisition, Logistics, and Construction (OALC)

Associated Strategic Goal: Empower Veterans to improve their well-being

Strategic Objective: Increase customer satisfaction through improvements in benefits

and services delivery policies, procedures, and interfaces

Associated Performance Measure(s): No public-facing measures are associated with this issue

FY 2017 Milestones:

VA is committed to achieving compliance with IPERA and the reduction of improper payments continues to be a high priority for the overall effort to strengthen financial management. Since 2015, VA reported increases in improper payment rates due to the continued improvement of testing surrounding acquisitions. This increased improper payment rate has continued into 2017 with the addition of three new programs that are also reporting errors related to contract compliance. These examples of noncompliance represent a systemic challenge for VA that requires judicious corrective actions to ensure there is no impact to Veterans' access to care. Implementation of these corrective actions to remediate improper payments associated with care in the community and other acquisitions for Veterans will take time to implement. It is possible that it will be a few years before VA is fully compliant. Although these programs are reporting improper payments over 10 percent, the noncompliance issue does not represent an actual loss or a budgetary impact to VA. Furthermore, VA is also working to reduce improper payments caused by the concurrent payment of VA benefits and drill pay. To address root causes of improper payments, VBA has a collaborative drill pay workgroup between VA Compensation and the DoD and continues to develop a solution for moving drill pay adjustments to a monthly process. Title 38, Code of Federal Regulations, requires VA to provide a Veteran with notice of a proposed adverse action and 60 days to provide evidence showing why the adverse action should not be taken. This due process requirement is the largest barrier to timely resolving drill pay

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improper payments, and will be noted in future AFRs.

To ensure accurate testing and reporting of improper payments, VA has made multiple improvements. For the Supplies and Materials program, VA developed testing procedures for payment testing under IPERA to better identify unauthorized commitments and pricing verification and developed an internal controls document detailing the direct to patient processes. VA also developed an alternative sampling plan (approved by OMB in June 2017) for Purchased Long Term Services and Support that reduces sample sizes to ensure Purchased Long Term Services and Support meets precision targets and allows VHA to increase resource investment into improving payment processes. VA also adjusted its sampling plan for VA Community Care to use a ratio-based estimate in order to meet precision targets. OMB confirmed a ratio-based estimate is in accordance with its Circular A-123 Appendix C requirements and does not require approval as an alternative plan. In addition, VBA Education Service now requests (1) school documentation for billing, attendance, and student transcripts; and (2) school catalog information verifying tuition and fees, as required by Title 38 CFR 21.4209, Examination of Records.

KEY RELATED LINK:

Review of VA's Compliance With the Improper Payments Elimination and Recovery Act for FY 2016

5/15/2017 | 16-04416-231 | [Summary](#) |

OIG SUB-CHALLENGE #3B: IMPROVING FINANCIAL REPORTING (OM, VHA, VBA, AND OI&T)

Overall, the CFS audit reported VA's complex, disjointed, and legacy financial management system architecture continued to deteriorate and no longer met increasingly stringent and demanding financial management and reporting requirements. As a result of the FY 2015 and 2016 CFS audit, OIG's independent auditor

reported that VA did not substantially comply with federal financial management systems requirements and the U.S. Standard General Ledger at the transaction level under the FFMIA. Also, the audit of VA's FY 2016 CFS identified six material weaknesses and two significant deficiencies—two more in total than the prior year. The independent auditors made recommendations for VA to address identified issues that ranged from specific, targeted actions to broader improvements in policies, processes, and systems. Additionally, VA is currently working with the U.S. Department of Agriculture to obtain financial services. In FY 2017, VA began efforts to standardize business processes and identify changes required for its systems modernization effort.

VA's Program Response

Estimated Resolution Timeframe:

VA estimates that it will achieve initial operating capability for the new financial system in Q1 FY 2020

Responsible Agency Official:

Assistant Secretary for Management (lead),
Assistant Secretary for IT, and Principal
Executive Director for OALC, VHA CFO, and
VBA CFO

Associated Strategic Goal and Strategic Objective: Manage and improve VA operations to deliver seamless and integrated support, enhance productivity, and improve efficiency of the provision of Veteran benefits and services

Associated Performance Measure(s): No public-facing measures are associated with this issue.

VA concurs that our legacy financial management system does not fully comply with the FFMIA. To address this major challenge, VA is currently working with a FSSP on VA's FMBT effort to migrate to a new integrated financial and acquisition management system, iFAMS. VA's FMBT effort will increase the transparency, accuracy, timeliness, and reliability of financial information resulting in

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improved fiscal accountability to American taxpayers, and offers a significant opportunity to improve care and services to our Veterans. The FMBT program goals capitalize on the opportunities for business process improvements to resolve systemic and procedural issues including:

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

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

In addition, VA has initiated targeted actions to address the material weaknesses and significant deficiencies reported in the FY 2016 CFS Audit. Specifically, the VBA has procured actuarial contract support for both education and compensation benefits. Additionally, efforts are being made to hire a certified actuary in early FY 2018 that will effectively address the material weaknesses and significant deficiency related to VBA. The VHA drafted and issued Summary Level Guidance in May 2017 for the major business and financial processes of VHA Community Care. VHA is working to supplement the high-level guidance with

detailed SOP by category of care. VHA kicked off the development of SOP by creating working groups to support the key processes within Community Care which include Cost Estimation, Obligations, Authorizations, Batch Processing, and Reconciliations.

To address the internal control material weakness noted for the reconciliation discrepancies between Fee Basis Claims System (FBCS) and FMS and the FBCS cost estimation process, VA collaborated and developed an automated solution for the FBCS to FMS Outpatient category of care reconciliation process. The FBCS to FMS Variance Dashboard was created to automate the calculation for outpatient care which will bring structure, standardization, and increased visibility to the back-end reconciliation process.

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

The Administrations and program offices are actively engaged and working to continuously improve and strengthen internal controls in financial management.

KEY RELATED LINK:

Audit of VA's Financial Statements for Fiscal Years 2016 and 2015

11/15/2016 | 16-01484-82 | [Summary](#) |

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OIG SUB-CHALLENGE #3C: IMPROVING MANAGEMENT OF APPROPRIATED FUNDS (OM, OI&T, AND VHA)

In FY 2016, OIG documented several instances of mismanagement of appropriated funds. Accordingly, in FY 2017, OIG reviewed several allegations received via OIG's Hotline regarding the potential waste or misuse of appropriated funds. In each of the allegations that were substantiated, OIG found that VA staff overpaid for services or benefits to VA employees, non-VA providers, or contractors. None of the overpayments were intentional or resulted in criminal or disciplinary actions against a VA employee or contractor. However, the deficiencies revealed the need for improved controls over payments and the need to implement policies and procedures to ensure the disbursement of appropriated funds is cost effective and prudent. In several instances, VA did not use the controls in place or did not fully consider all the available options.

VA's Program Response

Estimated Resolution Timeframe: 2020

Responsible Agency Official: Under Secretary for Health

Associated Strategic Goal: Manage and improve VA operations to deliver seamless and integrated support

Strategic Objective: Enhance productivity and improve efficiency of the provision of Veteran benefits and services

Associated Performance Measure(s):

Manage and improve VA operations to deliver seamless and integrated support

FY 2017 Milestones:

To address findings of overpayments, VA began collection activities on overpayments. VA is also updating policy and procedures to enhance controls so that disbursements are cost effective and prudent.

For overpayments related to Non-VA Care claims for physician-administered injectable drugs, VA completed these actions:

- An initial validation of the OIG findings and overpayments for Non-VA Care claims made by Florida VA Facilities (VISN 8) for physician-administered injectable drugs
- The initial corrective actions needed to resolve the OIG recommendations related to implementing Medicare Drug Schedules, and is proceeding with the Medicare pricing schedules' purchase and implementation for use in VA's FBCS
- Availability of the schedules in FBCS is on target for implementation in October 2017 with implementation to be accompanied by revised claims processing guidance and training for all VA voucher examiners
- Currently in the process of developing recommendations and a plan for remediation/recovery of the improper payments for physician-administered and injectable drugs
- VA will explore all appropriate remediation/recovery alternatives, including bills of collection and debt compromise. As community partnerships are vital to Veterans receiving timely access to high-quality care, VA will work closely with our community providers as we work to resolve these overpayment issues.

For overpayments related to VA's recruitment, relocation and retention incentives, VA completed these actions:

- Recommendation 9 of OIG's Audit of VA's Recruitment, Relocation, and Retention Incentives (OIG 14-04578-371) recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administration (HRA) to monitor facilities' compliance with VA Handbook 5007/46 requirements to initiate debt collection from individuals who did not fulfill their recruitment, relocation, or retention incentive service obligations.
- HRA will meet the requirements of the recommendation as follows: The proposed policy revision to VA Handbook 5007, part IV, chapter 2 will require all requests for

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waivers due to breach of service obligations to be submitted, through channels, to the Assistant Secretary for Human Resources and Administration. Such requests will be routed to the Office of Human Resources Management (OHRM), Compensation and Classification Service for technical review prior to approval. Previously requests for waivers were routed to the original approval official. This change elevates all requests for waivers to a higher level and will require technical review in VA Central Office. Additionally, VA Handbook 5007 will be revised to include an enhanced review process and template that requires certification that appropriate action has been taken to initiate debt collection, as appropriate.

- OHRM convened a workgroup with Workforce Management and Consulting, FSC, and Human Resources Information Service (HRIS) in April 2017, to discuss the debt collection reporting requirement outlined in recommendation 9 and debt waiver procedures for individuals who do not fulfill their recruitment, relocation, or retention incentive service obligations. Several complexities were identified related to report creation, tracking mechanisms, and report development. OHRM is to work with FSC and HRIS to finalize system capabilities and ensure that debt collection for the recruitment, relocation and retention incentives can be accurately tracked to meet OIG reporting requirements.
- Implementation of this recommendation is still in progress. Policy updates are pending final approval prior to being sent for concurrence. Policy revision tentative publication date is FY 2018.

In reference to the OIG report, *Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities* (15-01080-208), VHA validated that VISN 8 facilities made some overpayments for physician injected drugs, but needs to conduct a further detailed review, particularly of invoices from physicians that included physician injected drugs as a professional charge. VHA's FBCS pricing

software currently contains Medicare pricing algorithms for non-VA physician-administered drugs (other than orally administered) for charges invoiced by a facility on a facility invoice. VHA has reached out to the FBCS software contractor, Document Storage Systems, Inc., (DSS) to obtain the additional software and schedules necessary to price physician invoiced physician-administered drugs according to Medicare pricing requirements. The purchase of the FBCS Medicare Drug Average Sales Price Schedule will ensure its availability for pricing physician invoiced charges properly. VA has developed corrective measures for the issues and resultant overpayments associated with physician injectable drugs.

In reference to the OIG VISN-specific report, *Review of Alleged Misuse of VA Funds at the VA Pittsburgh Healthcare System* (15-02278-415), the site completed the following actions in FY 2017. The facility closed four recommendations. The facility implemented several corrective actions to address the OIG recommendations, including conducted an annual review of resident meal plans and evaluated the internal purchase of resident meals as an alternative to commercial sources.

KEY RELATED LINKS:

Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities
6/5/2017 | 15-01080-208 | [Summary](#) /

Audit of VA's Recruitment, Relocation, and Retention Incentives
1/5/2017 | 14-04578-371 | [Summary](#) /

Review of Alleged Misuse of VA Funds at the VA Pittsburgh Healthcare System
12/15/2016 | 15-02278-415 | [Summary](#) /

Review of Alleged Wasted Funds at Consolidated Patient Account Centers for Windows Enterprise Licenses
12/6/2016 | 16-00790-417 | [Summary](#) /

OIG CHALLENGE #4: PROCUREMENT PRACTICES

STRATEGIC OVERVIEW

In FY 2016, according to the Federal Procurement Data System, VA spent an estimated \$22.7 billion in contract actions. Therefore, it is imperative that VA ensures the controls over funds disbursed and project management of contracts is effective. In FY 2017, OIG conducted reviews regarding the award and administration of VA contracts. The deficiencies found indicate that VA is experiencing challenges in the management of construction and service contracts. VA must improve its acquisition processes and oversight to ensure the efficient use of funds. Further, OIG conducted a risk assessment of VA's Charge Card Programs and determined sufficient evidence existed to assess a medium risk of illegal, improper, or erroneous purchases within VA's purchase card program. OIG conducted several program reviews and the results indicate that VA still needs to improve its purchase card practices.

**OIG SUB-CHALLENGE #4A:
IMPROVING CONTRACTING
PRACTICES (VHA, OM, AND OI&T)**

OIG substantiated a Hotline allegation of improper management and oversight of minor, nonrecurring maintenance, and clinical specific initiative construction projects. The mismanagement of eight construction projects led to project cost overruns, delays, cancellations, unnecessary change orders, and additional work. In total, OIG identified approximately \$2.8 million in unnecessary costs and delays in completing projects needed to serve veterans. In addition, reviews of service contracts found project management and oversight was ineffective which adversely impacts VA's ability to ensure the value of contract deliverables and return on investment is adequate.

VA's Program Response

Estimated Resolution Timeframe: Ongoing

Responsible Agency Official: Under Secretary for Health

Associated Strategic Goal: Strategic Goal 3, Manage and improve VA operations to deliver seamless and integrated support

Strategic Objective: Enhance productivity and improve efficiency of the provision of Veterans benefits and services

Associated Performance Measure(s): In my work unit, steps are taken to deal with poor performers who cannot or will not improve.

FY 2017 Milestones:

This response is only for action taken by VHA Procurement to improve contracting processes. VHA Procurement and Logistics has initiatives to track contract compliance and improve contract oversight. VHA Chief Procurement and Logistic Officer continues to monitor contracting actions via a metrics program that tracks contracting competition; Socio-Economic Program Performance; Procurement Action Lead Time; Federal Procurement Data System reporting; Procurement satisfaction; Integrated Funds Control, Accounting, and Procurement to eCMS reporting; eCMS contract Closeout; and Service Disabled Veteran-Owned Small Business/Veteran-Owned Small Business awards. VHA Chief Procurement and Logistic Officer has provided additional guidance to Contracting Officer Representatives to improve service contract oversight and included the Acquisition Utilization Specialist positions in the Logistics/Supply Chain Management service standardized organizational structure effort.

Improvements in Contracting Practices are ongoing. VHA Procurement continues to use a rigorous metrics program and worked with the

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VA Senior Procurement Council to create a contract compliance tool for implementation in FY 2018.

In reference to *Review of Alleged Mismanagement of Construction Projects at the VA Medical Center in Clarksburg, West Virginia*, issued March 24, 2017, (report 15-03231-319), the facility has completed the following actions in FY 2017: The facility retrained contract personnel in need of training on the Independent Government Cost Estimate (IGCE) procedures and policies. The facility revised the workflow associated with developing IGCE and conducted inter-rater reliability studies as needed. The facility completed training of personnel on preparing project-funding requests.

In reference to the OIG VISN-specific report, *Review of Alleged Mismanagement of Construction Projects at the VA Medical Center in Clarksburg, West Virginia* (15-03231-319), the site completed the below actions in FY 2017. The facility closed four recommendations. The facility implemented several corrective actions to address the OIG recommendations, including retrained contract personnel in need of training on the IGCE procedures and policies; revised the workflow associated with developing IGCE and conducted inter-rater reliability studies as needed; and completed training of personnel on preparing project-funding requests.

In reference to the OIG VISN-specific report, *Review of Alleged Improperly Sole Sourced Ophthalmology Service Contracts at the Phoenix VA Health Care System* (15-01818-213), all four recommendations and the report are now closed.

KEY RELATED LINKS:

Review of Alleged Mismanagement of Construction Projects at the VA Medical Center in Clarksburg, West Virginia
3/24/2017 | 15-03231-319 | [Summary](#) |

Review of Alleged Improperly Sole Sourced Ophthalmology Service Contracts at the Phoenix VA Health Care System
2/1/2017 | 15-01818-213 | [Summary](#) |

Review of Alleged Waste of Funds on a Cloud Brokerage Service Contract
1/31/2017 | 15-02189-336 | [Summary](#) |

OIG SUB-CHALLENGE #4B: IMPROVING PURCHASE CARD PRACTICES (VHA, OM, AND OI&T)

Based on prior year OIG purchase card reviews and risk assessments of VA charge card programs, OIG assessed the VA purchase card program as medium risk. In FY 2017, OIG conducted a review of purchase card programs based on a Congressional request and a Hotline allegation. Each of these reviews disclosed VA inappropriately made unauthorized commitments by splitting purchases and exceeding the micro purchase limit. VA approving officials did not adequately monitor purchase card transactions that led to the misuse of purchase cards. As a result of the purchase card misuse disclosed in OIG reviews, VA employees did not protect the Government's interests when obtaining supplies and services. VA employees have a fundamental responsibility to be effective stewards of taxpayer resources and to safeguard those resources against unauthorized commitments and improper payments.

VA's Program Response

Estimated Resolution Timeframe: Oversight of the purchase card program is continuous.

Responsible Agency Official: Under Secretary for Health

Associated Strategic Goal: Manage and improve VA operations to deliver seamless and integrated support

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Strategic Objective: Enhance productivity and improve efficiency of the provision of Veterans benefits and services

Associated Performance Measure(s): In my work unit, steps are taken to deal with poor performers who cannot or will not improve.

FY 2017 Milestones:

Split requirements are a continuous challenge for any purchase card program. VHA Procurement has collaborated with the OM's OIC to identify and correct incidence of split requirements.

Facility repairs are susceptible to split requirement because of their urgent nature and the difficulty in determining the final cost before using the purchase card. VHA Procurement will continue to work with Network Contracting Offices to reduce the incidence of split requirements by adding contracts for facility repair services.

Starting in April 2016, VHA substantially reduced unauthorized commitments in the prosthetic implant purchases by implementing a pre-authorization process.

In reference to the *Review of Alleged Unauthorized Commitments for Prosthetic Purchases at VA Network Contracting Office 3* (15-03678-210), the report reviewed a one-time occurrence at Network Contracting Office 3. Service Area Office East quickly fulfilled the requirements of two of three recommendations and OIG closed the recommendations. Ratifications of unauthorized commitments (recommendation 1) are in progress. It is important to note that in 2016, during the course of OIG's review, Network Contracting Office 3 merged with Network Contracting Office 2; Network Contracting Office 3 no longer exists. Service Area Office East reviewed the issues raised by OIG for underlying causes and found that human error due to training deficiencies was the primary cause and that staff did not deliberately intend to make improper purchases. Service Area Office East

properly trained all prosthetics purchase card holders in the contracting systems and reporting requirements and removed the individual in question from a supervisory role. Additionally, Service Area Office East reconciled the actual purchase card orders to remove the mistakenly reported items and entered accurate information. Any actions that could not be specifically reconciled are resolved via the ratification process. Current processes and Service Area Office East oversight preclude the likelihood of this mistake happening in the future. Any reporting of transactions that circumvent established systems is immediately flagged by the Service Area Office for resolution. Service Area Office East's continuous monitoring of all Network Contracting Office operations will ensure adequate oversight and accountability of Network Contracting Office internal controls.

In reference to the *Review of Alleged Irregular Use of Purchase Cards by VHA's Engineering Service at the Carl Vinson VA Medical Center in Dublin, Georgia* (15-01217-249), the facility completed the following actions in Fiscal Year 2017: The facility reviewed micro-purchase card transactions by Engineering Service cardholders and identified unauthorized commitments. The facility ratified requests for the unauthorized commitments. The facility established an oversight mechanism to ensure that approving officials without the required approval were assigned no more than 10 cardholders each. The facility leadership ensured that appropriate administrative action was taken for each individual who made unauthorized commitments. The VISN issued a memorandum to the facility director citing requirements for adherence to Federal and VA regulations and policies. The VISN provided training to Engineering Service card holders on not splitting purchases, procuring supplies and services without proper authority, and making purchases exceeding established dollar limits.

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At the time of this response, OIG has not published the report, *Review of Use of Non IT Funds for IT Costs*.

At the time of this response, OIG has not published the report, *Review of Misuse of Purchase Cards at VISN 15*.

KEY RELATED LINKS:

Review of Alleged Use of Wrong VA Funds To Purchase IT Equipment
9/29/2017 | 16-00753-338 | [Summary](#) /

Review of Alleged Irregular Use of Purchase Cards by VHA's Engineering Service at the Carl Vinson VA Medical Center in Dublin, Georgia
6/27/2017 | 15-01217-249 | [Summary](#) /

Review of Alleged Unauthorized Commitments for Prosthetic Purchases at VA Network Contracting Office 3
6/12/2017 | 15-03678-210 | [Summary](#) /

OIG CHALLENGE #5: INFORMATION MANAGEMENT

STRATEGIC OVERVIEW

Secure systems and networks are integral to supporting the range of VA mission-critical programs and operations. Information safeguards are essential, as demonstrated by well-publicized reports of information security incidents, the wide availability of hacking tools on the internet, and the advances in the effectiveness of attack technology. In several instances, VA has reported security incidents in which sensitive information has been lost or stolen, including personally identifiable information, thus exposing millions of Americans to the loss of privacy, identity theft, and other financial crimes. 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. The FY 2016 FISMA report included 31 recommendations necessary to improve VA's information security program. Also, OIG substantiated Hotline allegations which document the need for an improved approach to information security.

OIG SUB-CHALLENGE #5A: EFFECTIVE INFORMATION SECURITY PROGRAM AND SYSTEM SECURITY CONTROLS (OI&T)

In both FISMA work and other reviews of VA systems, OIG continues to see information system security deficiencies similar in type and risk level to findings in prior years and an overall inconsistent implementation of the security program. Moving forward, VA needs to ensure a proven process is in place across the agency. VA also needs to continue to address control deficiencies that exist in other areas across all VA locations. OIG continues to find control deficiencies in security management, access controls, configuration management, and contingency planning. Most importantly, OIG continues to identify significant technical weaknesses in databases, servers, and network devices that support transmitting financial and sensitive information between VAMCs, VAROs, and Data Centers. This is a result of an inconsistent application of vendor patches that could jeopardize the data integrity and confidentiality of VA's financial and sensitive information.

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VA's Program Response

Estimated Resolution Timeframe: December 2017

Responsible Agency Official: Assistant Secretary for the Office of Information and Technology (OI&T)

Associated Strategic Goal: Manage and improve VA operations to deliver seamless and integrated support

Strategic Objective: Evolve VA IT capabilities to meet emerging customer service/empowerment expectations of both VA customers and employees

Associated Performance Measure(s): There are no public-facing performance measures for this issue

VA is well positioned to resolve high-impact potential risks to the Department through existing Enterprise Cybersecurity Program (ECSP) initiatives, which address tactical and strategic cybersecurity-related actions. The ECSP continues to serve as VA's approach to sustaining a robust cybersecurity ecosystem, aligned with federal policies and the evolving threat landscape. Tactically in 2015, VA developed Plans of Action (POAs) to address OIG FISMA audit findings, address additional gaps, and identify the capabilities needed to resolve the highest priority risks. The POAs are supported by a 3,000+ line item integrated master schedule that is on track to be completed by the end of CY 2017. Progress against the schedule is reported weekly to the VA Chief Information Officer. From an ongoing strategic perspective, the ECSP created eight domains to address the full spectrum of security-related capabilities, including Access Control, Identification, Authentication; Application and Software Development; Cybersecurity Training and Human Capital; Governance; Medical Cyber; Operations, Telecommunications, and Network Security; Privacy; and Security Architecture, Engineering, and Design. For each finding and domain

activity, VA performs comprehensive reviews to better understand the resources required to execute the tactical and strategic activities, respectively.

VA continues to enhance its existing cybersecurity risk management strategy, which aims to improve effective reporting of security control implementation status and risks. In order to enhance the risk management strategy, VA is working to evolve its current Assessment and Authorization Case Management function, which will allow for improved oversight and consistent enforcement of compliance and status tracking. As described in the Case Manager Handbook, the Case Manager role will strengthen VA compliance by providing oversight of expiring Authority to Operate (ATO) determinations and tracking of Plans of Action and Milestone status associated to security controls. Further allocation of resources assigned to the Case Management function, in addition to enhanced reporting processes surrounding Security Control Assessments, enhanced dashboard reporting within the Knowledge Service (KS), and standardized training for system stakeholders, will allow for more consistent execution and correct reporting of the security controls by the System Owners.

In addition to enhancement of the Case Management function, VA has begun to integrate the National Institute of Standards and Technology (NIST) Risk Management Framework (RMF) with the NIST Cybersecurity Framework (CSF). Aligning CSF and RMF will provide visibility into cybersecurity risk at the system-level and enterprise-level. The RMF provides VA with the ability to analyze compliance, measure operational risk, and ultimately make risk-based determinations for an information system's ATO. Risks to VA information systems are documented and tracked within VA's Governance, Risk, and Compliance tool, in accordance with VA Handbook 6500.3 Assessment, Authorization,

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and Continuous Monitoring of VA Information Systems. VA designed existing RMF process workflows for routinely analyzing control implementation during ATO issuance. These workflows support the risk acceptance process used by the Authorizing Official to accredit the system. VA continues to update processes within its RMF capabilities to further analyze applicable risks to VA information systems (e.g., residual, accepted, mitigated) in support of its risk management program.

VA is also internally managing cybersecurity risk consistent with federal statutes, related OMB guidance, and NIST guidelines. This capability, referred to as the OI&T Information Security Board (ISB), provides governance for enterprise information security by reinforcing the business need for effective enterprise security, in order to achieve a sustainable security capability in line with VA's mission. The ISB approaches cybersecurity as an enterprise-wide risk management issue, and provides input to VA's Enterprise Risk Management (ERM) framework for leadership awareness. The ISB also functions as a centralized body to elevate and make authoritative decisions on enterprise cybersecurity risk. At its core, the ISB is designed to facilitate enhanced cybersecurity performance monitoring and measurement by actively tracking VA's progress against the M-17-25 security domains and associated FISMA metrics on an ongoing basis. Furthermore, the ISB is structured to monitor other key performance indicators related to the OIG audit and other internal and government-wide reporting requirements. Using these metrics, VA executive leadership is better able to:

- Measure the effectiveness of VA's cybersecurity program
- Identify improvement opportunities in VA cybersecurity capabilities and processes

- Prioritize procurement and/or enhancement of cybersecurity capabilities and processes
- Make risk-informed decisions regarding the Department's cybersecurity risk.

Cumulatively, these metrics enable OI&T leadership to make strategic decisions around identifying and mitigating security gaps. This approach allows VA to continually assess its cybersecurity posture on an annual, quarterly, and ad-hoc basis. Moving forward, VA will further enhance the use of metrics and align/tailor future metrics based on OMB guidance and the NIST CSF.

Among VA's ongoing initiatives to monitoring security controls and VA's environment is the continuous monitoring program, which provides awareness around VA's information security posture, vulnerabilities, and threats to support organizational risk management. In alignment with Department of Homeland Security's Continuous Diagnostics and Mitigation (CDM) program, VA's continuous monitoring program is an integral part of VA's ECSP. VA is actively working to implement CDM capabilities to include vulnerability management as part of the Operations, Telecommunications, and Network Security security domain within the ECSP.

KEY RELATED LINKS:

Review of Alleged Failure of the National Work Queue To Perform in Production
8/10/2017 | 16-01401-295 | [Summary](#) /

VA's Federal Information Security Modernization Act Audit for Fiscal Year 2016
6/21/2017 | 16-01949-248 | [Summary](#) /

Review of Unauthorized System Interconnection at the VA Regional Office in Wichita, Kansas
4/6/2017 | 16-00376-133 | [Summary](#) /