

**Office of Inspector General, Department of Veterans Affairs
Statement before the Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
United States House of Representatives
Hearing on Department of Veteran Affairs Challenges
March 12, 2009**

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss critical challenges facing the Department of Veterans Affairs (VA) and provide our assessment of VA's effectiveness in addressing these challenges. Every year, the Office of Inspector General (OIG) prepares a list of management challenges facing VA which is included in VA's Performance and Accountability Report (PAR). In the most recent PAR, we reported on serious problems across VA in the areas of health care delivery, benefits processing, financial management, procurement practices, and information management. These issues were identified as a result of the OIG's continuing oversight of VA through national audits, healthcare inspections, Combined Assessment Program (CAP) reviews, and criminal and administrative investigations. In fiscal year (FY) 2008, we issued 127 reports; as of February 27th, for FY 2009, we have issued 43 reports.

Today we will focus on the following challenges because of the Subcommittee's particular interests: mental health services, including post traumatic stress disorder and suicide prevention; medical research; review of issues associated with Community Based Outpatient Clinics (CBOCs), Vet Centers, and contracted care; quality management; Department of Defense(DOD)/VA transition to care; progress in implementing the new GI Bill; Veterans Benefits Administration's (VBA) claims processing operations; information technology issues; procurement; and oversight of VA funds provided in the American Recovery and Reinvestment Act of 2009.

Mental Health Issues

Veteran mental health issues remain a major focus of OIG activities. The issue of the availability and provision of appropriate treatment for veterans with post traumatic stress disorder (PTSD) and related mental health conditions was reviewed in several OIG reports. An August 2008 report, *Healthcare Inspection Post-Traumatic Stress Disorder Program Issues at VA San Diego Healthcare System, San Diego, California*, found that clinical mental health care for veterans must be the first priority of the hospital staff, even though there are significant and important research questions that must be answered for the benefit of all veterans at risk. We made recommendations to restore the balance between research and clinical care.

In a January 2009 report, *Healthcare Inspection Allegations of Mental Health Diagnosis Irregularities at the Olin E. Teague VA Medical Center, Temple, Texas*, we reviewed the allegation that veterans were given the clinical diagnosis of adjustment

disorder to disadvantage them in the VBA disability evaluation process. We found that the two processes were separate; that veteran's diagnosis varied depending upon the clinical facts presented during the visit; and that diagnosis were not always consistent between providers. However, we did not find data to support that veterans were disadvantaged in the disability determination process through the use of an adjustment disorder diagnosis.

Through reports on a number of individual veteran's cases, it is clear that veterans' mental health issues often are complicated by substance and alcohol abuse. OIG championed VA's change in policy to permit substance and alcohol abuse issues to be addressed simultaneously with ongoing mental health issues. Our inspection reports continue to address this issue. A report that will be issued in early Spring will indicate that substance abuse is a complicating factor for many veterans, in a higher proportion among returning Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans, and is a topic that demands more attention as more needs to be done to improve treatment and outcomes in this area.

We are currently completing work on a report requested by the Subcommittee on the mental health strategic plan, which we plan to issue in early April. Another report requested by the Subcommittee on an audit of the mental health initiative (MHI) fund will also be issued in early April. We will report on the Veterans Health Administration's (VHA) process for tracking funds allocated for the MHI fund, and whether performance metrics are effectively utilized to determine if the outcome of each initiative met VHA's intent. A report on the mental health care received in domiciliaries as required by Public Law 110-387, Veterans' Mental Health and Other Care Improvements Act of 2008, will be issued later this year.

Medical Research

We have published a number of research reports since we last testified before the Subcommittee. Our most recent report, [Healthcare Inspection Review of the Veterans Health Administration's Use of Appropriated Funds for Research](#), was completed at the request of the Subcommittee and found that VA spends appropriated research funds on research topics that are relevant to the current health care requirements of veterans.

OIG has reviewed and reported on instances where compliance with VA research procedures did not occur, and made recommendations that were agreed upon by VA for change. One report, [Healthcare Inspection Human Subjects Protections in One Research Protocol VA Medical Center, Washington, DC](#), focused upon the use of a medication called varenicline (Chantix®) in a particular VA research study, following an incident in which a veteran alleged that Chantix® caused him to become aggressive and engage in inappropriate activities. Our review focused on the timeliness of patient notification following warnings from FDA, the adequacy of the informed consent process, and the reporting of adverse events. We found that the facility Pharmacy Service responded appropriately to communications in notifying providers of these

newly defined risks. However, the Research Service did not ensure that patients with PTSD who were also enrolled in a smoking cessation study received adequate and timely notice of these risks. We further found that the facility failed to ensure that patients in this study who had taken Chantix® signed an addendum to the consent form disclosing these risks.

In another inspection, *Healthcare Inspection Human Subjects Protections Violations at the Central Arkansas Veterans Healthcare System, Little Rock, Arkansas*, we were asked to determine the validity of allegations regarding human subjects' protection violations in research. We substantiated the allegations of documentation irregularities and human subject protection violations and found that the affiliate Institutional Review Board (IRB) was aware of the problems and failed to appropriately follow up on the issues. We found missing documentation and failure to report serious adverse events. We also substantiated the allegation that the IRB failed to identify and address serious and/or continuing noncompliance and failed to ensure that investigators had the requisite skills to conduct their research. We identified a number of systemic issues which placed human subjects at risk and substantiated that the facility's Research and Development (R&D) Committee failed to protect human subjects. While we found that current facility leadership has made significant improvements to the R&D program, the persistence of problems indicates that the R&D program as a whole at this facility may reflect a culture of noncompliance. We recommended that the Under Secretary for Health should determine if it is appropriate to continue human research at the facility, and if the decision is to continue, should provide a plan to ensure that research complies with VHA standards.

We are currently working on a review of VHA's human research protocols to determine if veterans have given their consent to participate in research studies. We have conducted an online survey of VA facilities that conduct research as well as randomly visiting 30 sites. This report will be issued by late Spring.

In May 2008, we issued an audit report, *Audit of Veterans Health Administration's Oversight of Nonprofit Research and Education Corporations*, addressing the need to improve VA oversight of their Nonprofit Research and Education Corporations (NPCs). VA has almost 90 NPCs located in about 40 states with an oversight and management structure that is multi-layered including responsibilities at the Department level, within VHA, and at the NPC level. We found that because VHA did not provide the needed oversight of NPCs by establishing clear lines of authority, implementing effective oversight procedures, and requiring minimum control requirements for activities, NPCs did not implement adequate controls to properly manage funds, safeguard equipment, and guard against conflicts of interest.

As a result of this audit, the Under Secretary for Health agreed to convene a steering committee to clearly define the associated oversight authorities of the VHA Nonprofit Corporation Oversight Board, the Nonprofit Research and Education Corporation Program Office (NPPO), and VHA's Chief Financial Officer. This steering committee was also tasked with the development of a policy that can provide

programmatic direction to the NPCs. The NPPO was tasked to work with the Office of General Counsel to further develop and implement additional administrative controls to enforce NPC compliance on issues related to conflict of interest.

Community Based Out-Patient Clinics, Vet Centers, and Contracted Care

This Subcommittee recognized the importance of CBOCs and Vet Centers in providing care for veterans. With your support, we have completed a national review of Vet Centers and we are currently analyzing data and plan to issue a report this Spring. We will begin a series of reviews of CBOCs to ensure that veterans receive quality care at these facilities. The inspections will be performed in a similar fashion as our CAP reviews of VA Medical Centers.

We have initiated an audit to examine whether VHA has adequate management controls to oversee CBOC operations including performance measures, monitoring, and reporting mechanisms. Six years ago, CBOC operations were buried amidst the primary care lines of the various facilities, transparency was lacking, and VHA did not have basic information about CBOC operations. Generally, we expect this audit to identify opportunities to improve national and local management controls needed to ensure the effective operation of CBOCs. We plan to identify whether there are any gaps in national or local policies. Controls may vary based on whether CBOCs are VA or contractor-operated. We will focus on differences in the way these facilities are managed between VA and contractor-operated clinics.

We reported on the failures of a VA contractor to properly ensure veterans who underwent endoscopy were provided quality medical care, [Healthcare Inspection Gastroenterology Service Issues at the VA Southern Nevada Healthcare System, Las Vegas, Nevada](#). As the use of contracted medical care is likely to increase as VA expands its provision of health care beyond fixed facilities, through Project Hero and related health care contracts, we will begin to review the quality of care provided to veterans under these programs. We will work with VA as they begin to more actively address the issue of health care quality provided under contract services.

Quality Management

VA is taking steps to improve internal controls over selected quality improvement processes. In a January 2008 report on the Marion, Illinois, VA Medical Center, we recommended and VA agreed to issue a national quality management directive that would standardize the collecting and reporting of VA hospital quality management data. The OIG has actively contributed to VA's effort to establish the directive and looks forward to its issuance. As a result of events at Marion, Illinois, and several smaller VA hospitals, VA agreed to develop and implement a mechanism to ensure that VHA's diagnostic and therapeutic procedures are appropriate to the capabilities of the medical facility. The OIG believes that the tailoring of diagnostic and treatment procedures to the capabilities of the hospital is an important national safeguard that will help ensure that VA facilities practice within their "comfort" level. This internal control, when in

place, should improve the consistency in the quality of more complex procedures that often require significant hospital support in addition to the skill required by the physicians and support team that perform the procedure.

The OIG is focused on improving the hospital privileging process. During our CAP reviews, we are reviewing the privileging process and the requirement that appropriate data be used to support the hospital's decision to privilege a physician to provide care or perform procedures at VA hospitals. VA's peer review process was reviewed by OIG. Oversight of hospital performance from the Veterans Integrated Service Networks' level of command was significantly lacking when viewed from the perspective of standards and requirements for performance in VA directives. We made recommendations to strengthen and improve the peer review program.

We recently completed an evaluation of VHA medical facilities' quality management (QM) programs which will be published this month. The purpose of the evaluation was to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts, and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results. The OIG conducted this review at 44 VA medical facilities during CAP reviews performed across the country during FY 2008. This reports notes that there were two facilities with significant weakness in their quality assurance program, and makes recommendations regarding other quality assurance programmatic findings.

DOD/VA Transition to Care

The transition of active duty servicemen and women to VA remains an important topic of OIG review. We published a joint report with the DOD Inspector General that made recommendations for improvement of the care provided to returning OIF/OEF veterans, one of which was enacted into law, a provision allowing VA to provide Home Improvements and Structural Alterations grants to eligible veterans prior to discharge from military service. An outgrowth of prior OIG work in 2007 is the DOD/VA Reporting and Analysis Data Mart which, when it is fully populated, will permit the analysis of transition to care issues by creating cohorts of veterans based upon their year of discharge from DOD. This data mart requires additional attention on the business rules that are used to incorporate the various files into the database.

We have continued to improve the data available in our previously published data set and will report on access to mental health care in one state later this month. This report will demonstrate the importance of contracted care to supplement fixed VA facilities and clinics to provide timely access to medical care. In addition, the analysis of data in this cohort fashion permits contrasts to be drawn between OIF/OEF and veterans who were not assigned to these theaters, between active and reserve/national guard soldiers, and between medical diagnoses made before and after discharge from DOD. When fully operational, the DOD/VA Reporting and Analysis Data Mart should

provide an important resource for research, budget modeling, and health care planning for VA and DOD.

GI Bill Implementation

The OIG has provided oral briefings to the relevant congressional oversight committees' staff on VA's progress in implementing the Post 9/11 Veterans Educational Assistance Act of 2008 (new GI Bill) (Public Law 110-252). After a long planning period, VA has made progress in the current quarter; however successful implementation remains a difficult and risky challenge due to the inherent difficulties in creating the software tools, limited VA Office of Information and Technology (OI&T) development resources, vulnerabilities in VBA staffing estimates, and aggressive project scheduling requirements. In the coming months, VA will need to complete its primary plans for software development and implement contingency plans.

We have some concerns that VBA may need more staff than currently planned since officials have acknowledged reducing planned hiring by 48 employees (8 percent) due to space limitations. Further, VBA's estimate is based on annualized workload, rather than the peak seasonal workload expected during the beginning of the school year. Also, VBA's projected workload estimate did not include consideration of greater participation because of the current economic climate. Inadequate staffing can potentially delay claims processing. However, VBA is exploring possible solutions, such as rehiring annuitants with needed expertise.

VA's contingency plan identifies significant project risks, mitigation strategies, decision dates to deploy alternate plans, and estimated resource requirements. We are continuing to monitor the feasibility of some mitigation strategies that are more resource intensive, such as adding more employees to support the use of manual processes. For example, if the functionality to make recurring housing payments is delayed, the contingency plan calls for hiring 263 additional employees to initiate these monthly education payments. Clearly, implementing a manual process would lack the controls an automated system could offer.

Completion of the business requirements for the long-term solution may be delayed because many VA subject matter experts are focused on the interim solution. We will continue to monitor plan adjustments and additional planning/project deliverables, including the Integrated Master Schedule, to assess further potential impediments to program implementation. We will focus our efforts on identifying and evaluating potential weaknesses in assumptions underlying project feasibility determinations, schedule, costs, and risk assessments.

VBA Claims Processing Operations

Large inventories of pending claims for compensation and pension benefits have presented VBA with its most difficult challenge. Making headway has proven difficult because VA faces an increasing disability claims workload from returning OIF/OEF veterans, reopened claims from veterans with chronic progressive conditions, and additional claims from an aging veteran population. The complexity of benefits laws, court decisions interpreting those laws, technology issues, workload, and staffing issues contribute to VA's benefits processing challenges. Increases in VA funding levels has enabled VA to hire additional claims examiners that may help reduce the backlog of pending claims, but the increase in staff requires training and development to incorporate it into a productive workforce. Recent revelations of claim-related documents being found in shredders and intentional misdating of claims to improve productivity statistics can diminish the public trust of VBA. All of these factors will continue to present VA with major challenges in timely and accurate processing of disability claims.

Included in our FY 2009 appropriations was additional funding to create an inspections unit to perform systematic reviews of VBA's Regional Offices (VARO). This Division will conduct inspections to evaluate how well VAROs are accomplishing their mission of providing accurate and timely benefits and services to veterans and their dependents. The goal of the inspection program is to complete at least 12 inspections each fiscal year, allowing coverage of all 57 VAROs within a 5-year period. We plan to conduct our first inspection by the end of this month.

In FY 2008 and continuing in FY 2009, we have increased our presence in and oversight of VAROs through our national audits and reviews. OIG teams conducted evaluations onsite at 16 VAROs during FY 2008. The focus of much of our work is to help identify opportunities to improve the accuracy and timeliness of VBA's claims processing. For example, we recently issued a review of claim-date accuracy, [*Review of VA Regional Office Compensation and Pension Benefit Claim Receipt Dates*](#). We are also finalizing several audits related to VBA claim-related mail and mailroom processing, the "Site Visit" program that reviews Compensation and Pension functions, and a special review of management controls to prevent fraudulent payments for retroactive benefits of \$25,000 and above. The last three reports should be issued within the next month and will be provided to the Subcommittee.

This week we expect to issue a final report on the Systematic Technical Accuracy Review (STAR) program which measures the accuracy of claim processing decisions made in all regional offices. Our results indicated the STAR process did not effectively identify and report errors in compensation claim rating decisions and overstated the compensation rating claim accuracy. Additionally, VBA did not fully implement rating consistency review plans.

We are currently evaluating a sizable number of claims that have been pending more than 365 days to determine how VBA can improve its timeliness in processing

these claims. We are also initiating an audit to evaluate the effectiveness of VBA's Control of Veterans Record System, which tracks the location of claims folders within VBA offices. Because a lost or misplaced folder can lead to unnecessary delays in claims processing, we believe this audit will provide helpful recommendations to improve services to veterans.

With regard to VBA staffing, in September 2008, the OIG issued a report, *Audit of the Impact of the Veterans Benefits Administration's Special Hiring Initiative*, on VBA's hiring initiative to reduce the claims backlog. We are planning to begin another review to examine the effectiveness of VBA's efforts integrating new staff into their workforce.

Information Technology Issues

VA faces significant challenges in meeting the requirements of the Federal Information Security Management Act (FISMA). In our FY 2008 FISMA audit, we reported that VA had made no progress toward eliminating the material weakness in information technology (IT) security controls and little progress toward remediating the major deficiencies in IT security. VA has identified over 17,000 system security risks and developed corresponding Plans of Action & Milestones that need to be remediated to improve its overall information security posture. Consequently, our audit results support that a material weakness still exists related to the implementation of VA's agency-wide information security program. Legacy IT infrastructure and longstanding control weaknesses continue to place financial information and veterans' medical and benefits information at risk of unauthorized use and disclosure. OI&T has acknowledged that much work remains, especially in the areas of data security and privacy and infrastructure improvements.

Although the consolidation of IT functions and activities under the CIO has addressed some security issues, VA was not in full compliance with the requirements of FISMA in FY 2008. While progress has been made implementing components of the agency-wide information security program, we continue to identify significant deficiencies related to access controls, configuration management controls, change management controls, service continuity practices designed to protect major applications, and general support systems from unauthorized access, alteration, or destruction.

VA did define policies and procedures supporting its agency-wide information security program with the issuance of various information security directives and handbooks. Additionally, VA met several major milestones during the implementation of its information security program during this period. Specifically, VA has certified and accredited over 600 of its major applications and general support systems, initiated privacy impact assessments of its major applications and general support systems to identify and reduce unnecessary holdings of personally identifiable information, and implemented some technological solutions, such as secure remote access, application filtering, and portable storage device encryption to improve the security control protections over its mission critical systems and data.

We are currently performing another audit to evaluate whether VA is managing its information technology capital investments effectively and efficiently and to determine why VA was late in submitting Exhibit 300s (an agency's funding justifications for IT capital investments) to the Office of Management and Budget (OMB) for budget year 2010. Without a defined and disciplined process for managing IT investments, VA will continue to lack reasonable assurance that annual funding decisions for IT capital investments make the best use of VA's available IT resources. Our primary focus is to identify whether VA had implemented the corrective actions needed to prevent delinquent Exhibit 300 submissions in the future.

IT capital investments can provide solutions that significantly enhance the delivery of veteran health services and benefits. On the other hand, if not properly planned and managed, they can become costly, risky, and unproductive. The risks inherent in VA's current capital investment control environment and VA's current inability to identify IT capital investment needs by the established deadlines make it vital for VA to take immediate actions to strengthen its oversight to ensure the overall success of the IT capital investment program.

Procurement

We continue to identify deficiencies in VA's procurement process, including the solicitation, award, and administration of its contracts. In the past year, we have issued over 10 reports illustrating these deficiencies and have provided information on individual contracting actions to the Deputy Assistant Secretary for Acquisition, Logistics, and Construction. These deficiencies are identified during pre-award and post-award reviews of Federal Supply Schedule (FSS) contracts. Although VA's Office of Acquisition, Logistics, and Construction has made an effort to identify and correct problems, and institute policies to improve VA's acquisition program, the decentralization of VA's acquisition program makes this difficult to accomplish. VA does not have a system that can accurately report what was purchased, when it was purchased, how it was purchased, from whom it was purchased, and at what price it was purchased.

Our report, [*Review of Enterprise-Wide PC Lease Awarded to Dell Marketing, L.P.*](#), on VA's contract with Dell to standardize personal computers, as well as installation and other services, showed that the solicitation and award processes were technically compliant with Federal Acquisition Regulations. However, the review also found that the contract was not necessary or in the best interest of VA because the approach limited competition, did not fully consider the needs of VA customers, and would not achieve one of the stated goals of VA-wide standardization. In addition, we found that the decision to lease the personal computers was based on a faulty pricing analysis that incorrectly showed that leasing was more cost effective than purchasing.

Another report involving gastroenterology services for the VA Southern Nevada Healthcare System in Las Vegas, Nevada, revealed that a contract was inappropriately

entered into by the Chief of Medicine, as opposed to a warranted contracting officer as required by law.

With regard to VA's difficulties administering contracts, we issued three reports that illustrate VA's challenges in monitoring performance. Our September 2008 report, *Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements*, showed that VA lacks reasonable assurance that it received the services it paid for because of ineffective controls to monitor performance. Strengthening controls over performance monitoring of these sharing agreements could save VHA about \$9.5 million annually or \$47.4 million over 5 years. In a July 2008 report, *Healthcare Inspection - Alleged Research Funding Irregularities at the Central Texas Veterans Health Care System Temple, Texas*, we found that VA failed to properly administer a contract for the use of a magnetic imaging scanner. In a March 2008 report, *Audit of QTC Medical Services, Inc.'s Settlement Offer for Overcharges under Contract V101(93)P-2099*, we found that VA was overcharged \$6 million by QTC Medical, Inc., because QTC was not following the terms of the contract and VA had not established appropriate controls to monitor charges.

We plan to issue a report later this month on the implementation and effectiveness of e-CMS, which is VA's electronic contracting management system. e-CMS was designed to standardize the procurement process and provide visibility regarding VA procurements but our audit found that the system was not being used by VHA as directed.

A sample of our ongoing work includes a review of VA's interagency agreement with the Navy Space and Warfare Systems Command for IT services, an audit of disability examinations conducted by VA and those conducted by contractors, and a report summarizing issues identified in pre-award reviews of non-competitive health care resource contracts and compliance with VA policy.

In March 2008, the General Service Administration convened a Multiple Award Schedule Advisory Panel to review the structure, use, and pricing for FSS contracts. VA awards and administers FSS contracts valued at approximately \$7.5 billion annually, about 60 percent of which represent pharmaceuticals, medical/surgical supplies, and medical equipment. In August 2008, at the invitation of the panel, we made a presentation demonstrating the significance of key contract clauses, such as the price reduction clause, which ensures fair and reasonable prices throughout the term of the contract. Industry panel members have recommended that GSA remove this clause from the contracts. We have concerns that such actions would result in the Government paying significantly higher prices than similar commercial customers.

VA's Office of Acquisition, Logistics & Construction has implemented some and proposed other additional policies to improve and provide better oversight of the VA acquisition program. These include the establishment of the Acquisition Academy in Frederick, Maryland, to improve the quality and efficiency of training initiatives and development for the acquisition workforce; the utilization of contract review boards to

improve the oversight of large dollar procurements prior to award; increased oversight of field procurement activities by conducting onsite reviews; and the training of Regional Counsel attorneys to provide advice and guidance to local contracting entities.

The decentralization of VA's acquisition functions often results in inconsistent application of these policies and initiatives as evidenced by our findings relating to the implementation of e-CMS. In 2008, VA employed the services of a contractor to review and make recommendations regarding VA's acquisition structure. Although the contractor submitted a detailed report that delineated several reorganization options to improve VA's procurement activities, none have been implemented.

American Recovery and Reinvestment Act Funds

VA received \$1.4 billion under the American Recovery and Reinvestment Act of 2009 for non-recurring maintenance across VHA facilities; repairs and other projects in the National Cemetery Administration (NCA); hiring of VBA employees and VBA IT systems. As a proactive step, we plan to assess risk, internal controls, and planning processes in areas that receive stimulus funds, for the purpose of identifying the potential for improper payments, and to assess VA's ability to execute its plan in a cost effective and timely manner. We also plan to audit VHA and NCA contract and grant programs to identify improper payments, provide accountability for expended funds, and evaluate the success of specific projects; and evaluate other Recovery Act projects.

Conclusion

The OIG will continue to work with VA in addressing these challenges in meeting the needs of veterans for quality and timely health care and benefits. We appreciate the strong support and interest of the Subcommittee in our independent oversight work, and we will continue to focus our efforts in priority areas such as mental health, medical research, and implementation of the new GI Bill.

Thank you again for the opportunity to appear before the Subcommittee. We would be pleased to answer your questions.