

**STATEMENT OF  
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BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
HEARING ON  
"OFFICE OF INSPECTOR GENERAL'S OPEN  
RECOMMENDATIONS: ARE WE FIXING THE PROBLEMS?"  
JUNE 9, 2010**

Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss one of the Office of Inspector General's (OIG) major responsibilities which is to make recommendations to VA management to improve programs and services provided to veterans. Accompanying me today is Mr. Richard Ehrlichman, Assistant Inspector General for Management and Administration.

On balance, VA does a good job of implementing OIG report recommendations in a timely manner. The percentage of recommendations implemented within 1 year has increased each year from fiscal year 2007 through 2009, reaching a level of 94 percent. VA performs relatively well based on comparative data that other Federal OIGs periodically reported to Congress. OIG will continue to invest resources and keep a focus on timely and full implementation on recommendations for improvement across VA programs and operations.

The OIG provides summaries on open recommendations in our Semiannual Report to Congress. The most recent Semiannual Report to Congress for the period October 1, 2009, through March 31, 2010, shows 107 open OIG reports with 640 open recommendations. Of the 107 open reports, 11 reports with 23 recommendations and monetary impact of over \$92 million, were pending over 1 year. The oldest open report was issued on September 30, 2005. In preparation for this hearing, we reviewed our inventory and as of May 31, 2010, we are now tracking 124 open reports that contain 756 recommendations for implementation. Of these 124 open reports, 16 are pending over 1 year and contain 45 unimplemented recommendations, with a monetary impact of just under \$92 million.

**OIG FOLLOW-UP PROGRAM**

Follow-up is an important component of OIG oversight work. The Office of Management and Budget requires a process to follow up and report on the status of OIG report recommendations. The OIG is also required to report in its Semiannual Report to Congress on the status of report recommendations. Moreover, after the Inspector General testified before this Committee in February 2007, we began providing quarterly updates to Congress and the VA Secretary on the status of open report

recommendations, with an added emphasis on those recommendations pending over 1 year.

OIG staff take great care in developing recommendations for improvement that are clear and specific; provide a yardstick to measure improvement and gauge full implementation; and afford VA program officials an opportunity to implement the improvements within 1 year. Since 2007, we have worked closely with VA officials to develop recommendations for corrective action that can be realistically implemented within a year. As such, OIG no longer accepts VA implementation plans that take more than a year to complete, except under the rarest of circumstances and only when measurable timelines are provided. In some instances, based on OIG staff evaluation, VA program offices take corrective action while we are onsite or in the period between issuing a draft report and when the final report is published. When this happens, we close out the recommendation as fully implemented and reflect the action in our final report.

However, a majority of the reports we issue contain open recommendations for improvement. Once a final report is issued, OIG follow-up staff in the Office of Management and Administration begin a process of tracking them until fully implemented. Independent public accounting firms collaborate with the OIG to track recommendations contained in the *Federal Information Security Management Act of 2002* audit and the *Audit of VA Consolidated Financial Statement*.

For each report, we separately list recommendations for improvement and any related monetary impact we expect VA to derive from implementation. The staff begin a tracking process, with controls in place to focus on full implementation within our 1-year goal. The first OIG follow-up request is sent to the responsible VA program office 90 days after the report is published.

In each follow-up status request we seek a description of what actions have occurred toward implementing the recommendations during the preceding 90 days. We set a 30-day deadline for VA officials to respond in writing. The response must contain documentary evidence such as issued policies, certifications, or other material supporting any request to close recommendations. Our intermediate goal is to obtain evidence that VA is making progress in implementing recommendations. If we do not receive a timely reply, or if we determine VA's efforts appear to be falling behind schedule, we schedule a face-to-face meeting to discuss how to get implementation back on track.

OIG follow-up staff coordinate with OIG line officials who worked on the report. To ensure VA's implementation plans remain on track, they discuss the documentary evidence VA submits with the status reports. If a report recommendation remains unimplemented, OIG staff repeat this follow-up cycle every 90 days. Once a report passes the 6-month mark and we determine implementation is unlikely within the 1-year goal, we increase the frequency of discussions with OIG line staff and VA program officials, and ensure the appropriate senior management officials in the OIG and VA recognize the probability of missing the 1-year target for implementation.

In Appendix B of our Semiannual Report to Congress, we present tables on open reports and recommendations. In the first table, we provide a matrix with totals for both open reports and the associated unimplemented recommendations. The table further breaks the data into those open less than or more than 1 year, and provides the same data by VA Administration or Staff Office. The second table shows only those reports and recommendations that are unimplemented for more than 1 year. In this table, we show the report title, date of issue, responsible VA organization, monetary impact, full text of each recommendation, and an indication of how many recommendations on each report are still open.

### **OIG FOLLOW-UP OVERSIGHT REVIEWS**

The OIG also conducts follow-up reviews of our audit and inspection work. For example, our Office of Healthcare Inspections conducts Combined Assessment Program (CAP) reviews of VA medical centers. These cyclical reviews evaluate how well VA medical centers are accomplishing their mission of providing high quality medical services to veterans. When healthcare inspectors return to a VA medical facility on a subsequent CAP, they review VA's implementation plans from the earlier CAP in order to validate implementation, evaluate the effectiveness of the recommended changes in fixing problems, or in some cases to identify repeat deficiencies.

We also perform follow-up reviews on our national projects. For example, in May 2008, the OIG issued *Follow-Up Healthcare Inspection - VA's Role in Ensuring Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*. This followed up on a July 2006 report, *Healthcare Inspection - Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*, which described the health status of and services provided for a group of service members and veterans who had received inpatient rehabilitative care in VA facilities for traumatic brain injury (TBI).

Three years after completion of initial inpatient rehabilitation for TBI, many of these patients continue to have significant disabilities. Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) support for TBI patients is extensive. While case management has improved, long-term case management is not uniformly provided for these patients, and significant needs remain unmet. OIG will continue to monitor VHA's progress toward achieving consistent delivery of case management services for this select group of injured veterans.

In another pair of reviews, *Healthcare Inspection - Use and Reprocessing of Flexible Fiberoptic Endoscopes at VA Medical Facilities* (June 2009) and *Healthcare Inspection Follow-Up - Colonoscope Reprocessing at VA Medical Facilities* (September 2009), we reported on reusable medical equipment reprocessing (RME) issues. The first report determined that facilities had not complied with management directives to ensure compliance with reprocessing of endoscopes, resulting in a risk of infectious disease to veterans. The failure of medical facilities to comply on such a large scale with repeated alerts and directives suggests fundamental defects in organizational structure. A follow-up inspection 2 months later provided results for all facilities not previously

inspected and for facilities previously found to be non-compliant with VHA's directive on RME reprocessing. Among the 129 facilities inspected in August 2009 during our follow-up review, all 129 were compliant with respect to posting model specific standard operating procedures, and all facilities had adequate documentation of demonstrated competence for reprocessing staff except for one facility. However, we continue to be concerned about this issue and we are reviewing and reporting on RME processing as part of our CAP reviews.

In March 2010, we issued *Audit of the Fiduciary Program's Effectiveness in Addressing Potential Misuse of Beneficiary Funds*, which found similar to those in our June 2006 report, *Audit of VBA Fiduciary Program Operations*. In fact, we found that VBA had failed to take and complete promised actions in response to 3 recommendations made in our 2006 report. For example, in 2006 we recommended that VBA determine appropriate Fiduciary Program staff caseload levels and staffing requirements. In response to this recommendation, the then-Under Secretary for Benefits stated that VBA would conduct a work measurement study and convene a work group to closely examine Fiduciary Program staffing at VA regional offices (VARO) and to make recommendations regarding case workloads. During our 2010 audit, we found that VBA did not implement the actions they had previously agreed to take, including not issuing a staffing and workload model. Fiduciary Program staffing has been left to the judgment of individual VAROs. As a result, we found that a wide variation exists in the number of beneficiaries managed by individual Legal Instrument Examiner, ranging from 188 to 1,576 beneficiaries.

In April 2009 we issued *Follow-Up Audit of Veterans Health Administration Major Construction Contract Award and Administration Process* to determine whether VA implemented corrective action plans in response to the recommendations we made in the February 2005 *Audit of Veterans Health Administration Major Construction Contract Award and Administration Process*. This report contained 12 recommendations to strengthen VHA's contract award, administration, and project management. The then-Under Secretary for Health concurred with the 2005 report recommendations and provided corrective action plans. Nine of the 12 recommendations involved the establishment of a Quality Assurance Program. VHA had established a Quality Assurance (QA) Service, but this service lacked written policies, procedures, and performance measures. Further, the QA Service lacked a staffing plan to ensure it met all of its major quality control responsibilities. We also found that VHA did not fully implement the 2005 report recommendation to implement more effective project management oversight to manage and reduce construction schedule slippage from a national perspective or the recommendation to establish an effective program to ensure the timely close-out of major construction contracts. VHA officials have taken actions to address our most recent recommendations; however, the corrective actions should have been put in place 5 years earlier.

#### **VA'S PROGRESS IN IMPLEMENTING OIG RECOMMENDATIONS**

In the area of OIG's benefits inspections of VBA's regional offices, VBA officials have taken timely action to correct monthly benefits paid to veterans that we identify during our

inspections as inaccurate. We provide a daily list of identified claims processing errors during our site visits. VBA's efforts to establish a process to track and quickly fix these errors is a positive step toward ensuring veterans receive accurate benefits. We have had similar results correcting problems on the spot at VA medical facilities during our CAP reviews and Community Based Outpatient Clinic inspections.

In July 2009, we issued an *Oversight Review of Specialty Service Issues at the VA Montana Health Care System, Fort Harrison, Montana*. This was a review of actions taken by VHA to address allegations that a physician was providing substandard care and engaging in improper medical record documentation practices. In the course of performing this review, we had numerous concerns on the overall operation of a particular clinical service. As a result of the follow-up process, over 5,000 veterans had their care in this specialty area reviewed and, where necessary, some were contacted for further care. In addition, we found that the waiting times for one procedure were excessive; this has now been corrected.

In January 2008, we issued a report, *Healthcare Inspection - Quality of Care Issues, VA Medical Center, Marion, Illinois*, that concluded that the Surgical Specialty Care Line at Marion was in disarray, the oversight reporting structure for Quality Management (QM) reviews was fragmented and inconsistent, and there were significant deficiencies in the privileging of physicians, which is the process by which physicians are granted permissions by a medical center to perform specific diagnostic and therapeutic procedures. Although some of the recommendations dealt with specific issues that needed correction at Marion, there were also systemic recommendations for VHA, such as the need to standardize the collection and reporting of QM data throughout VHA and to ensure that VHA's diagnostic and therapeutic interventions are appropriate to the capabilities of the medical facility.

We used our cyclical CAP process to return to Marion in August 2009, and in a CAP report published in November 2009, we reported that of 13 QM areas reviewed, we found deficiencies in 10. Several QM-specific corrective actions initiated in response to the January 2008 report had not been fully implemented and did not consistently correct the conditions identified.

Since that time, VHA has worked in earnest to review and rewrite VHA guidance on Peer Review, Credentialing and Privileging, and Quality Management. In addition, in May 2010, VHA released their *Surgical Complexity Initiative: Aligning VA Medical Center Infrastructure with the Performance of Inpatient Surgery* directive. This model matches the capabilities of all aspects of a medical facility with the complexity of permitted procedures. This is a major step to ensure that VHA's diagnostic and therapeutic interventions are appropriate to the capabilities of the medical facility, thus ensuring that veterans receive surgical care in the appropriate setting.

## **OPPORTUNITIES FOR IMPROVEMENT**

Opportunities exist for VA to improve on its performance. As of March 31, 2010, we had two reports with open recommendations that represented over \$81 million in monetary impact. One report from September 2007, *Audit of the Acquisition and Management of*

*Selected Surgical Device Implants*, with over \$21 million in monetary impact, involved an open recommendation to improve the acquisition and management of selected surgical device implants (stents, aortic valves, and thoracic grafts). The other report from September 2008, *Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements*, with over \$59 million in monetary impact, has multiple unimplemented recommendations related to noncompetitive clinical sharing agreements.

Although we have not reached the 1-year mark on two significant administrative investigations issued in August 2009, *Administrative Investigation - Misuse of Position, Abuse of Authority, and Prohibited Personnel Practices, Office of Information & Technology, Washington, DC*, and *Administrative Investigation - Nepotism, Abuse of Authority, Misuse of Position, Improper Hiring, and Improperly Administered Awards, OI&T, Washington, DC*, we have concerns about the progress being made and commitment to implementation of OIG recommendations agreed to by VA program officials. Almost 10 months after we issued the final reports, only 3 of 45 recommendations are fully implemented.

## **CONCLUSION**

Lengthy delays implementing OIG recommendations not only cost VA money in unrealized savings but prevent veterans from benefiting from improvements in VA programs and services. We will continue to highlight those recommendations in need of attention in our reports to the VA Secretary, Congress, and in our regular meetings with senior VHA, VBA, and other VA officials.

Mr. Chairman, this concludes my statement. We would be happy to answer any questions you or other members of the Committee may have.