

**U.S. DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL'S
OPEN RECOMMENDATIONS:
ARE WE FIXING THE PROBLEMS?**

HEARING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

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**U.S. DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL'S
OPEN RECOMMENDATIONS:
ARE WE FIXING THE PROBLEMS?**

WEDNESDAY, JUNE 9, 2010

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:07 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Michaud, Perriello, Rodriguez, McNerney, Walz, Adler, Kirkpatrick, Stearns, Miller, Boozman, Buchanan, and Roe.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. Good morning. I want to call to order this meeting of the Committee on Veterans' Affairs.

I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks. Hearing no objection, so ordered.

I think we all know that the U.S. Department of Veterans Affairs (VA's) Office of Inspector General (OIG) plays a critical role in ensuring proper and efficient oversight of the Department's activities.

In the first half of the fiscal year 2010, from October 2009 to March 2010, the OIG issued 120 reports, identified nearly \$673 million in monetary benefits, and conducted work that resulted in 232 administrative sanctions.

It is evident that the Inspector General is essential in rooting out fraud, waste, and abuse within the VA. Today, we want to examine the progress that the Department of Veterans Affairs is making in complying with the OIG's recommendations.

Currently, the Office of Inspector General has a total of 115 open reports with almost 694 open recommendations that have yet to be implemented by the VA. The target date for implementation of these recommendations is within a year of publication. Although most of these open recommendations are on track to be completed within the 1-year timeframe, 16 reports containing 45 open recommendations are over 1 year old.

Additionally, recommendations on VA information security issues tracked by an independent auditor show that there are almost 40 open recommendations, 34 of which are carried over from previous years.

The timely implementation of these recommendations is crucial to ensuring our Nation's veterans receive the best care. Many of these recommendations play a critical role in ensuring patient safety and safeguarding veterans' information.

Additionally, of course, timely implementation not only reflects good management, but it always reflects responsible use of taxpayer money. The monetary benefit yet to be realized by these recommendations going unimplemented approaches \$100 million.

During this country's difficult financial time brought on by the recession, the VA must realize cost savings anywhere practical. This can be done straightforwardly through the elimination of waste and by acting in a timely manner to correct the issues identified in the OIG's recommendations.

The Office of Management and Administration's Operations Division is tasked with following up on the reporting and tracking of OIG report recommendations while ensuring that all allegations made by the OIG are effectively monitored and resolved in a timely, efficient, and impartial manner.

I am pleased that they are here today with Deputy Inspector General Griffin to share with the Committee their insights on this issue.

The OIG's reports for followup procedures are an essential component of the oversight process. Secretary Shinseki has commented many times on the importance of accountability and ensuring veterans' care comes first.

Every agency, including the VA, must be held accountable for implementing the OIG's recommendations in a timely manner and making certain our Nation's veterans are receiving the quality of care that is reflective of their service and sacrifice.

I recognize Mr. Stearns for an opening statement.

[The prepared statement of Chairman Filner appears on p. 36.]

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Good morning and thank you, Mr. Chairman. I look forward to this morning's discussion on what the VA must do to ensure the prompt and proper resolution of audit recommendations that are issued by the Office of Inspector General.

If you do not mind, I would like to read from the Inspector General Act of 1978, as amended, in which it states, "The head of a Federal agency shall make management decisions on all findings and recommendations set forth in an audit report of the Inspector General of the agency within a maximum of 6 months after the issuance of this report and should complete final action on each management decision within 12 months after the date of the Inspector General's report."

Now, Mr. Chairman, as of March 31st, 2010, there were 107 OIG reports with 640 open recommendations. While most of these recommendations are on track to close within the required 1-year period, I commend the VA for its timely implementation of those recommendations. We also know that there are many other recommendations that are over a year old.

The primary focus of this hearing is to get an update regarding the 11 open reports that are over 1 year old and the 23 recommendations in these reports that are still open.

According to the OIG's report, it could save taxpayers approximately \$92 million if these recommendations are implemented. We must ensure a concerted effort is underway to ensure prompt implementation of the OIG's recommendations in order to realize these savings.

So I look forward to working with both the VA and the OIG on this as well as future collaborative efforts that will allow us to make VA more efficient and to ensure an improved return on investment for the taxpayers and, more importantly, Mr. Chairman, to ensure that our veterans have access to the highest quality health care and benefit delivery system as possible.

I would point out the staff and I were talking this morning that the return on investment is \$14 to \$1. That is for every \$1 we spend with the OIG, we get \$14 back. This is an enormous success and something that we should continue.

And I would be interested to know, Mr. Chairman, how the VA stacks up with the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Labor (DoL) and other Federal agencies to see how well the other agencies are complying and implementing the OIG reports.

So, Mr. Chairman, I look forward to the testimony from our witnesses today and I welcome them too. Thank you.

The CHAIRMAN. Thank you, Mr. Stearns.

At this time, I welcome Richard Griffin who is the Deputy Inspector General for the Department of Veterans Affairs, accompanied by Robert Ehrlichman who is the Assistant Inspector General for Management and Administration.

Welcome. We appreciate you being here and look forward to your testimony. You are now recognized, Mr. Griffin.

STATEMENT OF RICHARD J. GRIFFIN, DEPUTY INSPECTOR GENERAL, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY RICHARD EHRLICHMAN, ASSISTANT INSPECTOR GENERAL FOR MANAGEMENT AND ADMINISTRATION, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. GRIFFIN. Mr. Chairman and Members of the Committee, thank you for conducting this hearing and for the opportunity to discuss one of the Office of Inspector General's major responsibilities, which is to make recommendations to VA management to improve programs and services provided to our Nation's veterans.

Accompanying me today is Richard Ehrlichman who has the responsibility for the followup activity at the Office of Inspector General.

Followup is a critical component of OIG's oversight work. The Office of Management and Budget (OMB) requires a process to follow up and report on the status of OIG recommendations. The OIG is required to report in its semiannual report to Congress on the status of report recommendations.

In addition, after the Inspector General testified before this Committee in February 2007, we began providing quarterly updates to the VA Secretary and Congress on the status of open report recommendations with an emphasis on recommendations more than 1 year old.

On balance, VA does a good job implementing OIG report recommendations in a timely manner. The percentage of recommendations implemented within 1 year has increased to 94 percent from fiscal year 2007 to 2009. VA performs well based on comparative data that other Federal OIGs periodically report to Congress.

We will continue to focus on timely and full implementation of recommendations for improvement across VA programs.

In some instances, VA takes corrective actions while we are still onsite and before a final report is published. When this happens, we close out the recommendation as implemented and reflect that action in our final report. Nonetheless, the majority of our reports contain open recommendations for improvement.

Once the final report is issued, OIG followup staff in the Office of Management and Administration begin tracking the recommendations until they are fully implemented. For each report, we separately list recommendations and related monetary impact we expect VA to derive from implementation. In each 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 evidence such as issued policies and certifications before we will close recommendations.

The OIG also conducts followup reviews of some of our audit and inspection work. During these reviews, we validate implementation, evaluate the effectiveness of the recommended changes in fixing a problem, and in some cases identify repeat deficiencies.

Examples of followup reviews include our audit of the Veterans Benefits Administration (VBA) Fiduciary Program and our health care work on reusable medical equipment.

Opportunities exist for VA to improve its performance. As of March 31st, 2010, we had two reports with open recommendations that represented over \$81 million in monetary impact. One report from September 2007 with over \$21 million in monetary impact involved a recommendation to improve the acquisition and management of surgical device implants. The other report from September 2008 with over \$59 million in monetary impact has multiple unimplemented recommendations on noncompetitive clinical sharing agreements.

Lengthy delays implementing OIG recommendations not only cost VA money in unrealized savings but prevent veterans from benefiting from improvements in VA programs.

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 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.

[The prepared statement of Mr. Griffin appears on p. 37.]

The CHAIRMAN. Thank you, Mr. Griffin.

Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman, for having this hearing today.

I have a couple of quick questions. My first, and I want to thank the panel for coming this morning, is why do you have a central-

ized followup staff rather than having the auditors or investigators who did the original report do the followup? Would it not make more sense to have those who did the original report do the followup?

Mr. GRIFFIN. In reality, it is a collaborative effort. The followup staff are really the traffic cops for receiving the reports from VA with the policies they have implemented or the procedures they have put in place or the training programs that they have created, those things do not require the absolute 100-percent attention of the audit staff or the health care personnel who did the job.

Certainly there is collaboration. If there is any question as to whether or not a recommendation should be closed based on the feedback that we have been given, we will consult with the expert who did the job and make sure that everyone is in agreement that it can and should be closed.

Mr. MICHAUD. Thank you.

My second question, actually it is a followup to Congressman Stearns' interest in exactly how does the VA stack up to other departments when you look at completing the recommendations?

Mr. GRIFFIN. From time to time, the Council of the Inspectors General on Integrity and Efficiency submit a report that goes to the Congress and goes to the White House and it lists a number of different performance measures involving the OIG's activities.

And as indicated in our testimony, we feel the 94-percent rate that has been demonstrated in the past 12 months by VA puts it on the high end of performance compared to some of the other departments.

Mr. MICHAUD. Thank you.

And do you feel that the OIG has all the tools that it needs to do an adequate job in looking at VA, the programs VA has, or do you need additional staffing or is there something that we can do differently that would make your job easier?

Mr. GRIFFIN. I believe in the fiscal environment that we are operating in today that the OIG, depending on the outcome of the budget request from 2011, will have the tools that it needs.

We are always looking for bright, young auditors, health care specialists, and criminal investigators to bring on board to attack some of the newer issues that seem to be confronting us in the information technology (IT) world and in some of the fraud arenas. But I feel like with the Committee's support in recent years, we have been properly staffed.

Mr. MICHAUD. And does the OIG for the VA work closely with the OIG for U.S. Department of Health and Human Services (HHS) since, for example, the federally qualified health care clinics, I can see where there would be a lot of synergies there?

Mr. GRIFFIN. There are synergies amongst a number of different OIGs, certainly in HHS with the health care work that they do and our health care staff. There is synergy with the Social Security Administration, which like VA has a huge benefits program and a process that they utilize to make benefits decisions and so on.

So there are a lot of different agencies that do have similar threads of activity and that is the purpose of the Council of Inspectors General to identify common problems, which every department might be facing. We make sure that we are sharing best practices

and are sharing findings of shortcomings in other departments that might be happening in VA.

Mr. MICHAUD. Great. Thank you.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Michaud.

Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman. I have a statement I would also like entered into the record.

The CHAIRMAN. So ordered.

[The prepared statement of Congressman Miller appears on p. 36.]

Mr. MILLER. And I have one question, Mr. Griffin. I was looking at your testimony. You talk about the 2005 report recommendation to implement more effective project management oversight. We are talking about 5 years that this oversight did not take place and corrective action should have been done, you say, 5 years earlier in your comments.

My question is, you know, what type of system of accountability can you put in place to prevent a 5-year lag of implementing recommendations?

Mr. GRIFFIN. Is that the major construction report you are referring to? Seven of the ten recommendations in that report address the need for a quality assurance program in order to make sure that we have proper oversight and proper program management for major construction.

A quality assurance group was established and this group was supposed to have addressed those things. When we went back and looked at it a second time, which we will do from time to time for validation, we found that, yes, the group was created, but it was not properly staffed. It did not have adequate policies and procedures in place. So it really was not a functional program oversight activity.

The other two recommendations simply were not addressed during that time period.

Mr. MILLER. I yield back.

The CHAIRMAN. You are yielding back when he did not answer the question. You asked, "What can you do to make sure that they do not go for 5 years without doing something." He responded that, yes, indeed, they went 5 years without doing something.

So how do we make sure there is oversight, if I may follow up on your question, Mr. Miller?

Mr. GRIFFIN. I think there are a number of things we do. We spotlight anything that has not been accomplished in 1 year and it goes in our semi-annual report so that the Committee can be aware when we have slippage on an issue.

I believe very strongly that hearings like this one are very helpful based on the flood of documentation we have received in the last 72 hours addressing various items that needed closure. So, again, I thank you for the hearing.

We do meet—

The CHAIRMAN. We should schedule one every week.

Mr. GRIFFIN. We will be here.

We do meet on a monthly basis with senior leadership from VA and certainly those issues that are the most difficult and most dated are the subject of those discussions also.

The CHAIRMAN. Thank you, sir.

Thank you, Mr. Miller.

Mr. Rodriguez.

Mr. RODRIGUEZ. You mentioned that the VA had responded by establishing a committee that basically was not responsive or, I guess, they just responded to try to fill a recommendation that was made and it took you 3 years to go back to look at that to see whether they were effective or not effective. And you found that they were not effective. Is that the case?

Mr. GRIFFIN. That is correct.

Mr. RODRIGUEZ. Okay.

Mr. GRIFFIN. But let me say that we, notwithstanding my previous response about resources, we do not have sufficient resources that we can go back and redo every audit and every health care inspection that we do. So some of them are selectively up for review.

Mr. RODRIGUEZ. What do we need to do to help you out to carry the job or what else do we need to do to try to get them to become more responsive?

Mr. GRIFFIN. I think the documentation of those reports that become more than 1 year old, which do get reported twice a year in our semi-annual report, could be a triggering mechanism so that between the OIG organization and the Committee and the Department, if we involve all three entities to focus on fixing it, I think you could get some synergy from that.

Mr. RODRIGUEZ. Because in the field, for example, I hear reports that they were giving out contracts to contract out, for example, somebody is given a contract to do work to pay doctors to provide a service, however, doctors are complaining because it takes 3 months to pay them.

And so how do we streamline that? How do we make it more responsive in terms of trying to get it done? I hate to think that we would have to ask for more reports and more reports because then that also bogs it down. So how do we get the system to become more responsive?

Mr. GRIFFIN. I think in the area of acquisition and procurement, it is complicated by the current division of labor that exists between our medical specialists and our acquisition specialists. And I think without both of those entities being on the same page, you cannot always have the medical side claiming that, well, I am the doctor, I know best about this particular device or this procedure. This is what I want. You buy it for me.

I think when it comes to acquisition, you need a little more independence in the acquisition function.

Mr. RODRIGUEZ. The other issues that we hear complaints about is, and I am sure we have made assessments in the past, the workload in the private sector versus the public sector. The doctors will tell me, Sir, I used to do 15 procedures and now I am doing half of them here. I could do more, but it does not happen.

How do we move on those? Do we have any—I am sure we have asked for studies in that area and comparisons. How do we move the system to become more responsive?

Mr. GRIFFIN. You are saying that VA doctors are complaining they do not get enough work?

Mr. RODRIGUEZ. Yes, sir.

Mr. GRIFFIN. I have not experienced that.

Mr. RODRIGUEZ. Well, I have direct people that have said, look, I used to do this and now I am being told that I only have this. They also get clients that, because they are 10, 15 minutes late, they get told to come back 3 months later, stuff like that.

How do we get past this situation?

Mr. GRIFFIN. I think I would defer to the Veterans Health Administration (VHA) on the performance measures for their doctors.

Mr. RODRIGUEZ. Okay. Now, you mention also you do not have the resources to follow back. And one of the arguments that we have talked about in trying to get the system sometimes, for example, on the computers, we talked about getting them, even an outside system, to look at moving them in that direction.

And have we come up with any other way of making it more responsive?

Mr. GRIFFIN. Making—

Mr. RODRIGUEZ. Well, for example, you mentioned IT, and the computer systems and all those when we make those mistakes, trying to get one hospital to talk to another and getting all that straightened out.

Is it going to require an outside group coming in basically doing it because they are unable to get it done themselves?

Mr. GRIFFIN. I think it is a combination. I think the IT world is so rapidly changing that the planning time and the implementation time in some instances is overcome by the next generation of tool that becomes available.

I know that there have been a number of projects that the Assistant Secretary has canceled because they became too old and they were no longer viable projects. And we applaud that.

But as far as whether or not the level of expertise is proper that exists in the Department, I would defer to Assistant Secretary Baker on the second panel on that question.

Mr. RODRIGUEZ. Okay. Now, if I can follow up, I know he had talked about the Capital Asset Realignment for Enhanced Services (CARES) Program that went around the country looking at vacancy issues.

From that, have we seen any need to do any followup on that? From your perspective, do you think we ought to be looking or inspecting any of our facilities for utilization purposes and those kind of things and maybe restructuring that?

Mr. GRIFFIN. I do not believe that the OIG Office has done any recent work on vacant buildings.

Mr. RODRIGUEZ. On occupancy rates and those kind of things?

Mr. GRIFFIN. Certainly if we have vacant buildings that we are paying to maintain and they are not being utilized, it would make sense that we should divest ourselves of those. But we have not done any recent work.

Mr. RODRIGUEZ. Are you doing any work right now on the new piece of legislation where we fund them in advance? I know it is going to take them a while to come into it and make the transfers there, but, we are doing that for the first time, so I am sure that is going to require them to do a lot of things differently.

But it is going to be able to plan in advance, so are we doing any assessments from your perspective or should we?

Mr. GRIFFIN. Now you are referring to——

Mr. RODRIGUEZ. The appropriations to fund direct appropriations a year in advance.

Mr. GRIFFIN. We have not looked at that. I think it makes sense to have the flexibility though.

Mr. RODRIGUEZ. Does it make sense for you to be able to look at it from the onset in terms of the implementation of it and see how that is going?

Mr. GRIFFIN. We could examine that if you would like. We do do the financial statement audit every year and look at all of the financial activities of the Department. And we could make it an adjunct to that perhaps.

Mr. RODRIGUEZ. Okay. Thank you.

The CHAIRMAN. Thank you, Mr. Rodriguez.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

Mr. Griffin, in reviewing the Combined Assessment Program (CAP) reviews of VA medical centers, are there specific items that the OIG finds recurring that would indicate a systemwide breakdown of procedures that should be addressed not only at the local medical center but also throughout all of the VHA through the use of a directive from the Central Office and what are these recurring items?

Mr. GRIFFIN. When we do a series of CAP reviews, normally we will look at eight or ten specific items. And when we have multiple findings on an item, we will do a roll-up report to VHA so that they can look at it from a systemic perspective.

One such item that we recently published was in the area of quality management. And we looked at 44 different facilities during the time period in question. We identified four that we thought had serious issues.

Mr. STEARNS. Was the VA medical facility in Gainesville, Florida, one of them?

Mr. GRIFFIN. No, it was not.

Mr. STEARNS. Okay.

Mr. GRIFFIN. But we specifically mentioned those four facilities in our report to VHA and we would expect that there would be followup activity by VHA on those.

Mr. STEARNS. Can you tell me those four facilities? Can you name them?

Mr. GRIFFIN. Manila, Honolulu, Marion, Illinois, and give me a minute and I will come up with the fourth one.

Mr. STEARNS. Okay.

Mr. GRIFFIN. Fayetteville.

Mr. STEARNS. Fayetteville. Okay.

Mr. GRIFFIN. Yes, sir.

Mr. STEARNS. And what are the recurring items?

Mr. GRIFFIN. There are occasional findings involving environment of care in our Community-Based Outpatient Clinic (CBOC) reviews, which mimic the CAP reviews. We have had recurring issues over contract management at each of the CBOCs.

Mr. STEARNS. But specifically are there any that involve patient safety?

Mr. GRIFFIN. Well, from the standpoint of quality management being your overall umbrella, which would include how well patients are being treated, whether you have the proper peer review processes in place, whether you are doing the proper after action and analysis when there is an adverse event, whether you are properly notifying family about adverse events, and so on.

Mr. STEARNS. So patient safety in those four hospitals you mentioned, is that a serious recurring problem?

Mr. GRIFFIN. I would not say patient safety per se. It is just that all of the activities, which I just touched upon, many of those may not have occurred at all four facilities, but some combination of those things were not happening at those facilities.

Mr. STEARNS. You mentioned in the followup audit of the VHA major construction award administration and cite that while the VHA officials have taken actions to address your most recent recommendations, the corrective actions should have been put in place 5 years earlier, I think is what you were saying.

So what do you believe is the root cause for these delays in implementing these corrective actions? Five years is a long time.

Mr. GRIFFIN. It is a long time. I am not able to give you an answer as to why it took 5 years.

Mr. STEARNS. Well, should we ask the VA then? But nobody on your staff could help us out here?

Mr. GRIFFIN. I could give—

Mr. STEARNS. Just from your observation. I mean, not necessarily scientific.

Mr. GRIFFIN. Again, in the followup process, when the quality assurance activity was documented in their directive and how it was supposed to work, someone in our organization must have been convinced that would address the issues. And it was only when we went back to do it, we realized that those seven items were not properly addressed.

Mr. STEARNS. Well, that is 60 months. You would think during that time, somebody could have taken care of that. I think a lot of us just want to see more efficiency at the VA. And, you know, the Chairman and I and others have talked about the backlog of processing and how slow it has been. In fact, we have given more money and more people for this, yet the backlog still remains there.

So thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Stearns.

Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman.

And, Mr. Griffin, thank you for being here and the work you do. I think we all understand that one of our main responsibilities here is hearings just like this to provide the oversight that is necessary because at the end of the day, it is all about how do we provide the best quality care and resources to our veterans while ensuring taxpayer dollars are watched more.

And so I have to say there is good news in here and I think we should applaud those things when they happen.

The endoscope issue was very troubling for many of us in that hearing and the way that that was pointed out, the hearing that

was done, the recommendations for oversight and the followup all happening between June and basically September of last year. To have the VA get clear marks on that is a sign that the system can work and it is working. So I very much appreciate you on that.

I wanted to just ask one question, I guess. It is dealing with, and I know it is a complicated one, the issue of procurement and contracting and this issue. It especially hits home in letting out of the contracts for the CBOCs that are so important in rural America. And these things seem to just continue to drag on and drag on and drag on. And the best intentions of everyone is, yes, this will be the date we will get it to you. And it just keeps getting pushed down.

And I am wondering, the recommendations go back to what Mr. Miller asked about in terms of project management and quality assurance programs. From the OIG's side of things, is there anything we can do there that is better in terms of cutting out fraud, waste, and abuse but moving these things forward? Is there anything you can say on that, Mr. Griffin, that will help me understand why it seems to take so long? I am not so certain that the time lag is doing anything to improve the contracting.

Mr. GRIFFIN. We always try to bring something to the attention of the Department at the earliest possible moment. We have only been doing these CBOC reviews for a number of months now, probably several months. But in each review that we did, we found that the contract was poorly written, each one was a little different, most of them called for a per capita payment basis tied to whether or not a veteran had been seen in the last 12 months.

There are terms for removing somebody from the rolls which means that you are not paying the contractor for that person for that particular time period and so on. And what we found in repeated visits to different CBOCs was that no one was paying attention to the terms of the contract.

So Dr. Daigh, from our staff, quickly brought that to the attention of VHA and told them you need a standardized contract that everybody understands and that everybody can apply across the board. And when someone dies or someone should be disenrolled for some other reason, we need to make sure that happens.

We need to make sure that when there are disincentive clauses included in the contract that the people managing the contract are aware of those and looking for opportunities to recover moneys that should not have been paid and so on.

But we did not wait until the end of a year or a year and a half worth of reviews. Once we realized that this was a systemic problem, we quickly called for a meeting with VHA. And Dr. Daigh sat down with them and explained what we were finding so that we can cut off the bleeding as early as possible.

Mr. WALZ. Well, I appreciate that because one of the things that I talked about here, I am very proud of what we have done in terms of enhancing VA and enhancing care for our veterans, but one of the things I have been talking about and warning everyone here about is if we are not good stewards of these dollars, that is going to be a tragedy in this, that we do not improve the care. So I appreciate you doing that as quickly as possible.

One last thing. VBA's process on employee effectiveness of how we are going to measure what we are getting done, how we meas-

ure work process and everything as it deals with again the backlog on this.

Are you seeing anything from the OIG's side of how do we ensure that is happening?

Mr. GRIFFIN. Well, we recently started a new initiative. That is the Benefit Inspection Division that goes out and does a review of five different categories to check on a number of things.

One is to check on the accuracy of the rating that was given to determine whether or not people have the proper training so that they can do it right the first time and not expend that extra amount of time redoing the claims.

And much like the contracts and CBOCs, when our staff finds a problem in the course of doing their daily reviews in the Regional Offices, on a daily basis, they provide to the director those claims that we reviewed in which we found problems with the rating determination and they fix them on the spot.

So I think what we are finding is the volume of work continues to grow and the lack of adequate training and the nuances of the rating schedule and the fact that you have so many new hires that it is like a perfect storm as far as what you need for good performance measures and program management that is not there right now.

Mr. WALZ. Well, I am afraid you are right on that. And that is one of the things we have a concern about at the end of the day is none of those things are going to get a reduction in the backlog of claims or inaccuracy which is, of course, the paramount issue, accuracy in the claim.

I yield back. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Walz.

Mr. Roe.

Mr. ROE. Thank you, Mr. Chairman.

And just to start off on what Congressman Rodriguez said, I, too, Mr. Griffin, have heard exactly the same thing specifically in colonoscopy. One of my good friends is a gastrointestinal (GI) physician at a VA and complains all the time that he could do twice as many colonoscopies if he were allowed to. When he was in private practice, he did. And I think that is a quality of care issue because it delays care of our veterans.

And I do plan on coming back next term and the quality of care issues are the ones that I want to focus on. I think that is paramount. That is why we have a VA hospital system—to provide the best quality of care that we possibly can.

And one of the questions I have is, and I really appreciate the work you all are doing. And I know in practice, we had a weekly conference, patient conference where we looked at all the difficult cases. We had a standard of care, but we did not have any person like yourself to come in because we all think we are providing good care.

But at the end of the day, maybe we are not, when you have someone objectively come in and look at that. So that is why it is important for you to continue doing what you are doing.

How robust, and I think one of the things that brought this up was the incident that occurred with the brachytherapy, that was not very good, and how robust is the evaluation and peer review

of dysfunctional or practitioners that are outside the standard of care?

Mr. GRIFFIN. How dysfunctional is it for—

Mr. ROE. No. I mean, how robust is your evaluation, I guess a peer review of practitioners who fall outside the standard of care like this physician in the brachytherapy case that we looked at last year?

Mr. GRIFFIN. Well, unfortunately, sometimes it takes a call to our hotline for a case to come to our attention or during the course of one of our cyclical reviews at a medical center, someone will approach a member of our staff and say you really need to look at this or that area.

When you talk about how robust is our ability to examine those areas—

Mr. ROE. Well, yeah, I guess. Well, both. I mean, how robust is your ability and then how does that investigation actually occur? And Congressman Walz brought up the colonoscopy issue last year, which I thought was handled very well once it was discovered.

Mr. GRIFFIN. Well, I can tell you that from when I first arrived at VA in 1997, we had 16 people in our health care unit to do quality oversight for the whole VA. Clearly, an inadequate number.

Mr. ROE. Inaccurate.

Mr. GRIFFIN. They are presently up to 119. They have a number of different disciplines. Dr. Daigh has been able to hire a number of excellent physicians, but he also knows that when we do not have the expertise on our staff we will go out and pay for that expertise and bring in an outside expert which is something we did in the brachytherapy work.

Mr. ROE. Well, another question I have then is on the CBOCs. There are, I do not know, 1,200 of them in the country, over 1,000 anyway. And the way the current oversight and investigation, there is an investigation or evaluation, I should say, every 20 years. And we just added \$50 million to hopefully get this down to 3 to 4 years.

Is that enough money? Do you have enough resources to do what we have asked you to do?

Mr. GRIFFIN. Well, the 20-year cycle is clearly unacceptable.

Mr. ROE. Yeah, it is.

Mr. GRIFFIN. We thought that 3 years would be a more reasonable number to work with. And if we get the additional funds, that is what we will do. We will make it a 3-year cycle.

Mr. ROE. And that is—

Mr. GRIFFIN. We are still building the database. Some of those are clinics that are run by a VA full-time equivalent. Some of them are private contractors.

So it kind of gets back to the question about does the private sector person have a greater caseload than the VA person. We are going to be able to do at that type of analysis on the CBOCs once we get a little more in depth in our database.

Mr. ROE. So we should be able to have that information in fairly short order, a couple of years, 3 years—

Mr. GRIFFIN. Right.

Mr. ROE [continuing]. Something like that?

Mr. GRIFFIN. Right. And we will do it after the 1st year and then we will continue to build upon it.

Mr. ROE. Well, you know, it is a huge system. You have over 300,000 employees in the VA system or around 300,000 people. That is an enormous job that we have asked you to do, but it is an incredibly important one.

And, again, as I know, when you look at what I thought I was doing well sometimes, when it is evaluated, you find out it is not. And it is not a problem to change once you get accurate information. It is not that you do not want to do the right thing. You may not know you are not doing the right thing.

So, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Roe.

Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Inspector Griffin, my understanding is that the OIG does not make recommendations for improvements that are expected to take longer than 1 year to implement. Is that correct?

Mr. GRIFFIN. Except in rare circumstances. And if there is a project that realistically cannot be done in a year, we will accept those recommendations as long as there is a timeline that shows here is phase one and by a date certain, we are going to have the alpha portion of this project completed. And here is the next date and the next date and we will at least track those activities.

Mr. MCNERNEY. Okay. You know, implementing OIG recommendations clearly has benefits both in terms of fiscally and in responsiveness of the VA to veterans' needs.

Are there any instances in which using VA assets to address OIG recommendations has detrimental effects in terms of direct services to the vets? Are there any cases that you are aware of?

Mr. GRIFFIN. No, I cannot say that I am. I suspect that if that were the case, we would have heard about it.

Mr. MCNERNEY. So you have a good feedback mechanism from the—

Mr. GRIFFIN. Absolutely.

Mr. MCNERNEY [continuing]. Providers? So okay. That is good. Do you feel that providing the OIG with additional authority in cases where the VA is severely late in implementing recommendations would be effective in assisting the VA with its obligations? In other words, how can additional resources be helpful to you or the VA in implementing your programs?

Mr. GRIFFIN. I do not know that it is a resource issue. I think that some of these issues are extremely difficult. And the reality also is that we have seen turnover in some of the most senior positions. We see it every 4 years obviously.

But in the middle of a term, you might have somebody who holds a top position for a couple years and he is gone. People are in an acting capacity during that time period. They are not always certain that they want to make a radical decision on something that is difficult. So I think there is a combination of factors that come into play.

Mr. MCNERNEY. Thank you.

Well, you recommended that the time it takes the VA to implement your recommendations has improved over the past. What do

you attribute that improvement to in the time that it takes to implement?

Mr. GRIFFIN. I think Mr. Ehrlichman has the percentages to demonstrate that improvement from 2007 through 2009 and I am sure he could answer the rest of that question.

Mr. EHRLICHMAN. Thank you.

What we have done, and we started it late in 2006, is myself and the Deputy OIG at the time went around and met with all of the principals throughout the Department, all the Assistant Secretaries and the Under Secretaries and their staff.

We talked about trying to change the followup process significantly and we talked about trying to come up with recommendations that were specific, measurable, that could be implemented within a year, and that we were going to have a lot more frequent contact. We were going to be a little bit more persistent.

If we were not hearing that there was progress, we were probably going to make an appointment, meet with them. We were going to bring the health care inspectors, the auditors, followup staff and we have done much better.

In 2007, we were at about 86 percent. In 2008, it went up to 88 percent. And the last complete fiscal year, we were at 94 percent implemented within 1 year.

Mr. MCNERNEY. So basically you made it a priority and you held their feet to the fire once the recommendations were made?

Mr. EHRLICHMAN. That and a lot more direct communications, a lot more meetings. As Mr. Griffin had mentioned, we began meeting on a monthly basis with principals in all the administrations and the staff offices and I think that has helped a lot, having the communications.

Mr. MCNERNEY. Okay. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you, Mr. McNerney.

Mr. Boozman, congratulations on your victory yesterday. You have to get the TV networks to concentrate on Boze rather than Booz.

Mr. BOOZMAN. Thank you, Mr. Chairman.

I think we need an OIG investigation as to whether or not you were behind my chair being broken over here.

I just have, and, again, this might be kind of a dumb question, but we have all of these things outstanding and some of them are important in regards to patient care. Others are important in regard to a monetary sense. And it all goes back to be important to veterans.

Do we prioritize which ones are the most important? Does that make sense? We have all of these things. It is almost overwhelming, and we have to be helpful and push this thing forward. Is there the ability to kind of rank the ones that we need to really get on the stick and use our ability with oversight to push forward?

Mr. GRIFFIN. I think clearly there is a need to realize which ones are most important. But when we start an audit or we start a health care review, we might think we know what the condition is that we are going to find, but we really do not know with certainty until we do it.

And when we have completed our work, if we do have recommendations, we will forward them to the Department to fix.

I would be shocked if the Department were to say anything other than those issues that are most critical for patient safety and those issues that are most critical from a monetary standpoint rise to the top of the pile. I would be very surprised if that was not the case.

But within the OIG, we might have our own views which ones are the most critical, but we do not rank our audits and inspections per se.

I think that if they were easy, the fixes would be made while we were on site which does happen on some occasions as I already mentioned. So I think it is the complexity of some of the issues and it is the huge decentralized health care system and benefit system that the VA represents that makes it difficult.

And as far as ranking them, it is not something that we do, but I would have to believe the Department evaluates things based on the criticality of the timing of the fixes.

Mr. BOOZMAN. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Boozman.

Mrs. Kirkpatrick.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

My concern is about inefficiencies in the followup process. So my first question is, why do you use a centralized staff to do followup rather than the auditors and the investigators who did the initial reports?

Mr. GRIFFIN. It is done on a centralized basis because the auditors and the inspectors who did the audit on inspection are doing additional work. They have moved on to do other work.

But while the followup group itself is pursuing closure of those recommendations, they will call upon the auditor or the lead health care inspector who did the job and consult with them on whether or not the response that we are getting to the recommendation satisfies the finding.

So it is a shared responsibility. It is centrally controlled here because, frankly, that is where most of the headquarters' replies are coming out of VHA and VBA and the Office of Information and Technology (OI&T) and the National Cemetery Administration (NCA). The senior managers are here. And those are the senior managers that we will meet with on about a monthly basis to make sure that people are aware of what is out there and what needs to be done.

Mrs. KIRKPATRICK. You talked about the need to standardize contracts. Do you use a checklist system when you are doing that followup review? I mean, is there some uniformity in terms of the staff review and how they work that process?

Mr. GRIFFIN. There is uniformity in the timing of our request every 90 days and we ask for a response within 30 days. But there is not a one-size-fits-all sheet that you could apply to every health care inspection and every audit or every administrative investigation and so on.

So that is why it is critical, as you point out, to have the subject matter experts collaborate with our followup team to make sure that we got it right.

Mrs. KIRKPATRICK. Well, my last question is about on-site review. It seems to me that that is probably the best way to garner the in-

formation about whether or not the different departments are doing their job. I guess I wonder why you do not do on-site review on every report.

Mr. GRIFFIN. Because it would be too manpower intensive to try and go back and redo every one. There is a number, a percentage, you know, that would make sense. It is not 100 percent. The exact number, I guess, depends on whether we are suspicious as to whether or not the recommendation and the proposed fix was the right fix. Perhaps we will get a call to our hotline where we get 29 to 30,000 calls a year. If we get multiple calls suggesting that we still have a problem in a certain area, that might trigger us to go back.

And our CAP cycle, which is a 3-year cycle, every time when we go back to a medical center, we will take a look at the previous report and we will see what the recommendations were in that report and we will validate whether or not, in fact, they were addressed to our satisfaction.

Mrs. KIRKPATRICK. Your answer conjures up one more question.

Mr. GRIFFIN. Okay.

Mrs. KIRKPATRICK. Would it not be better to do the CAP review every year as opposed to every 3 years?

Mr. GRIFFIN. Well, that is a resource issue. You know, we are at these medical centers for a week, which is not a long time, and that is why their scope is such that there is no way you can go in and look at every activity in a medical center.

So every 6 months or so, we will decide these are the pulse points as we call them, these are the areas that we are going to look at for the next 6 months. And if we have repeat findings on one or more of those, we will bring that to the attention of VHA so that we can say this is not something that we found at one medical center. This is something that eight out of the last ten seem to be having a problem with or, you know, 15 out of 20, whatever the number might be. And then they know, okay, it is not an anecdotal situation.

They either need to clarify the policy, write new policy or get on the phone and find out why someone is not following the policy.

Mrs. KIRKPATRICK. Thank you very much.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you.

Let me just wind up our questioning. First, thank you so much for your testimony, Mr. Griffin.

Given the open recommendations and especially the last recommendations, what is your sense? What is the most important outstanding recommendation either by policy issue or by money, that we should focus on to save money?

Mr. GRIFFIN. I think when you are talking about money and policy, I think procurement represents a huge dollar value for the Department. I think the acquisition area on a number of different fronts, not just the drugs that we purchase, but the clinical health care specialists that we contract for, the contracts that we have with medical experts from the affiliates, contracts at CBOCs—

The CHAIRMAN. What is the problem there? How would you define the problem?

Mr. GRIFFIN. I would define the problem that you have the acquisition staff in Washington writing policy for how procurement and acquisition should be done. You have a contracting officer who works for the Veterans Integrated Service Network (VISN) who is working for a different master. And you have some Contracting Officer's Technical Representatives (COTRs) that are working in conjunction with the contracting officers who are also out at the medical center taking their direction at the medical center.

And too frequently what we find is the acquisition regulations and even VA regulations about the order that procurements are supposed to occur in do not happen. In addition, there is inadequate attention to monitoring the performance of what is in the contract and there is a lot of money left on the table as a result.

The CHAIRMAN. Money left because there are not tough enough negotiations or is there anything—

Mr. GRIFFIN. I think negotiation is part of it. I think when you establish a contract, if you do adequate analysis of what the need is and you put the proper parameters in for where you are going to go to get that person or that item and then after the contract which is properly competed, if it is a competitive contract, you have a COTR that monitors compliance with what is in the contract.

The CHAIRMAN. Give us the name of that acronym.

Mr. GRIFFIN. I am sorry. That is the contract officer's technical representative.

So it is a combination of things, but part of the issue is the people who write the policy are back in Washington and where the rubber meets the road is out in the field. And as I alluded to earlier in some instances, we will have a medical expert who says forget about the supply schedule or forget about what you are hearing from them, I want this prosthetic for my patient.

And I am sure there are occasions when for medical reasons that is 100 percent correct and that prosthetic should be the one used. But I think there are a lot of times where the sentiment is we cannot be bothered with contracting and procurement issues. We have veterans to take care of. So you have that constant struggle.

The CHAIRMAN. I mean, the Secretary is recommending that we have a new Under Secretary for Acquisition and Procurement.

Do you think that would help, or does that further move the focus to Washington as opposed to the sites?

Mr. GRIFFIN. I think given the proper authority to the position, that can help.

The CHAIRMAN. Has the office ever looked at the decisionmaking process for deciding what drugs may be on the formulary that the VA uses? Have you ever looked at that?

Mr. GRIFFIN. I am not aware that we have done any recent work in that area.

The CHAIRMAN. There are situations where new drugs are coming on the market and the people who are deciding on the formulary are looking too closely at the direct cost.

Let us say hypothetically that a new diabetes drug is online and it costs \$50. The other drug costs \$1. Of course, it seems \$1 versus \$50 is a clear monetary decision and, yet, the \$50 drug one may help the quality of life of the patient. For example, taking a shot

once every 2 weeks instead of twice a day may prevent complications in the future, and we are saving money in the future.

That is a process where people have to make decisions. Have we never looked at that directly?

Mr. GRIFFIN. No.

The CHAIRMAN. Okay. We might want to.

How about the processes used for looking at innovation in general in the VA, new technologies, new equipment, new ways of doing things?

We have a lot of complaints about not having new innovations available. Is there no real way for this bureaucracy to make these decisions? We tend to reject new ideas as opposed to embracing them. Have you ever looked at the situation?

Mr. GRIFFIN. I cannot say we have looked at that, but I would hope that our relationship with our affiliates who do have a number of medical innovations happening in their facilities, and who are working hand in hand with our doctors on sharing best practices. I think that was part of the intent of the affiliate process in the first place, that it would be mutually beneficial.

The CHAIRMAN. I am sorry, could you explain the affiliate process?

Mr. GRIFFIN. We have all these affiliates with our medical centers. Some of these affiliates—

The CHAIRMAN. I do not know what you mean by affiliates.

Mr. GRIFFIN. Well—

The CHAIRMAN. Is that the name given to the medical centers?

Mr. GRIFFIN. No. We have a VA medical center—

The CHAIRMAN. Yes.

Mr. GRIFFIN [continuing]. That is collocated with a university hospital. And those university hospitals often are perhaps getting some of the new technology earlier. But because we are in partnership with them, hopefully we benefit from experience they may have with new innovations.

The CHAIRMAN. I do not know how we ask you to look at this or ask the Secretary but the whole notion of a big bureaucracy and how it deals with innovation, is a real problem.

I do not know how big companies such as Microsoft or IBM embrace new innovation. The VA is in areas where we should be actively searching out new innovations and new ways of doing things. It just seems that we act as a bureaucracy that pushes back rather than embraces innovation.

We will talk to you about that later. Maybe we need to look at that.

I thank you both for being here with us. Thank you, Mr. Griffin. We hope you will continue in your job. I guess in your official position, when several people have asked you about new resources you are not allowed to say you need new resources. OMB says that you do, and on about six or seven different occasions, you have said that you have a lack of resources. We will have to look at that and talk to you in an informal way and—

Mr. GRIFFIN. Well, I am hopeful that the support that the Committee gave us on the 2011 budget causes our resources in 2011 to increase. That is where I am at.

The CHAIRMAN. Thank you, sir.

Mr. GRIFFIN. Thank you.

The CHAIRMAN. We appreciate that.

Mr. GRIFFIN. Thank you for having the hearing, Mr. Chairman.

The CHAIRMAN. If our next panel will join us, please? We have the Department of Veterans Affairs, Dr. Robert Petzel, the Under Secretary for Health; accompanied by Roger Baker, the Assistant Secretary for Information and Technology, and Diana Rubens, the Associate Deputy Under Secretary for Field Operations for the VBA.

We thank you all for being here.

Dr. Petzel, your written testimony will be made part of the record and we look forward to hearing from you.

STATEMENT OF HON. ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY HON. ROGER W. BAKER, ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY AND CHIEF INFORMATION OFFICER, OFFICE OF INFORMATION AND TECHNOLOGY, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND DIANA M. RUBENS, ASSOCIATE DEPUTY UNDER SECRETARY FOR FIELD OPERATIONS, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. PETZEL. Good morning. Chairman Filner, Congressman Stearns, and Committee Members, we thank you for the opportunity to appear before you today to discuss the Department of Veterans Affairs work in responding to recommendations from the Office of the Inspector General.

Joining me today are Roger Baker, the Assistant Secretary for Information and Technology, and Diane Rubens, the Associate Deputy Under Secretary for Field Operations for the Veterans Benefits Administration.

I also want to thank the Deputy Inspector General, Mr. Griffin, for his testimony in the previous panel. Thank you and thank you to your employees for your tireless commitment to our veterans and improving care within VHA and benefits within the VBA.

I am pleased to be here today to talk about what is perhaps the most important element of VA's mission, ensuring we deliver the absolute best care and services to our Nation's veterans.

The CHAIRMAN. I am sorry. Let me interrupt. Did anybody from the Office of Inspector General stay? Okay, thank you. I believe you wanted to hear the response to your testimony, so I am glad somebody is here. Thank you.

I'm sorry, Mr. Petzel. Please.

Dr. PETZEL. In my more than 35 years with the Veterans Health Administration, I have seen remarkable advances in the quality of care we provide to veterans. These improvements were due to the dedication of VA's employees. It is a dedication that continues today.

However, these years have also had their share of setbacks, but hindsight has revealed we could have and should have in many ways done better by our veterans. We have an excellent system, but it is not a perfect one.

VA is committed to identify those areas where we can do or need to do more to improve and we value the OIG as an important partner in ensuring the accuracy, integrity, and accountability in the delivery of benefits and services to our Nation's veterans.

VA OIG helps us ensure that we are being as effective and as efficient as possible. We are also partners in identifying areas of waste, fraud, and abuse, as well as removing persons whose conduct is truly criminal.

This not only improves our operations as a Department in providing services to veterans, but it saves the American taxpayers millions of dollars every year and reaffirms the faith that veterans have in this Department. Much of this is about the matter of trust.

If I may provide a brief example that illustrates both the partnership we have with the OIG and how this relationship improves care, I direct you no further than our facility at Marion, Illinois.

The problems we experience at that facility are well documented. And it is thanks in part to the OIG that the facility is on the corrective course it is today. We are establishing a new leadership team there, changing the culture, and our veterans are already experiencing these improvements.

The scope of the OIG's work is immense and it is far reaching as its investigations can be specific to facilities or result in broad reviews of VA programs. Its reports have resulted in hundreds of recommendations for the Department ranging from administrative actions against specific personnel to large-scale policy reviews.

Additionally, the Department and the VA OIG maintain a strong relationship in identifying, investigating, and bringing to justice those who use their positions to defraud or harm veterans.

The administrations and staff offices involved with each of these reports work directly with the VA OIG to ensure that action plans are developed and implemented in a timely and appropriate manner to make this change positive.

This system gives VA the flexibility to respond quickly and effectively to reports and recommendations that the OIG has issued. The administrations and offices are in regular communication with the VA OIG to track the progress in responding to its reports and to identify what more needs to be done.

I think the effectiveness of this partnership speaks for itself in the 94 percent accomplishment of recommendations within the 1st year.

While VA OIG has significantly increased the volume of its reports and recommendations, VA is closing out these reports and recommendations as quickly as ever has. The VA OIG has identified 16 reports with 45 recommendations open for over a year. These are the second lowest numbers in each of these categories over the last 5 years.

Furthermore, Mr. Chairman, as I detailed in my written testimony, since that report, we have provided the OIG with progress updates on two of these reports and recommendations and we are confident that our actions on these outstanding reports will close them out.

In closing, Mr. Chairman, let me say it again. VA is committed to being a veteran-centric, results-driven, forward-looking organization that provides the best care and services possible to our Na-

tion's veterans. And we value the partnership we have with the Office of the Inspector General.

Thank you again for the opportunity to appear and I and my colleagues would be delighted to respond to any questions.

[The prepared statement of Dr. Petzel appears on p. 40.]

The CHAIRMAN. Thank you.

Mr. McNerney, do you have any questions for the Secretary?

Mr. McNERNEY. Thank you, Mr. Chairman.

Well, the improvements have been pretty impressive, at least the way they have been outlined here this morning, so I appreciate that effort, both your part and the OIG's part.

I have a specific question regarding traumatic brain injury (TBI). The OIG mentioned that the VHA's support for veterans with TBI is extensive, but that long-term case management is not uniformly provided within the VA and that significant needs remain unmet.

I recently wrote legislation that was passed into law to direct the VA to specifically assess the needs of TBI patients and develop initiatives to meet those needs.

Can you please inform me of an update on the VA's or give me an update on the VA's efforts to improve TBI care and treatment?

Dr. PETZEL. Thank you, Congressman McNerney. That is an excellent question.

The patients that are returning from Iraq and Afghanistan with traumatic brain injury are of deep concern to the Veterans Health Administration and to the Department in general.

We have in place now a program to screen all combat veterans for the presence of traumatic brain injury. To date, we have screened over 50,000 of these veterans and have identified 16,000 people that have symptoms of traumatic brain injury. They have undergone a second level assessment to see how severe that traumatic brain injury is.

The CHAIRMAN. Dr. Petzel, can I interject?

Dr. PETZEL. Certainly.

The CHAIRMAN. These are people who have come to the VA, right?

Dr. PETZEL. That is correct.

The CHAIRMAN. Have we not gone out to all people?

Dr. PETZEL. Well, we have gone out. I will get to that in a moment.

The CHAIRMAN. And when you say screening, can you define that process?

Dr. PETZEL. There is a tool that is used—

The CHAIRMAN. A questionnaire?

Dr. PETZEL [continuing]. A questionnaire that is used by a practitioner to assess—

The CHAIRMAN. And is that—

Dr. PETZEL [continuing]. The possibility of traumatic brain injury.

The CHAIRMAN. Does someone sit down with the questionnaire, with the—

Dr. PETZEL. That is correct. It is administered by a practitioner.

The CHAIRMAN. The reason I am asking is because the military uses the word screening and what they mean by that is a questionnaire, usually a few questions, and they do not sit down with any-

body. Somebody looks at them and if there are any yeses, they call them back, so everybody knows how to say no. That is a little different than sitting down with a qualified medical person for 45 minutes or an hour. I call that an evaluation.

I think the single most important step this country can take to deal with both traumatic brain injury and post-traumatic stress disorder (PTSD) is to have the evaluation be mandatory before or after combat, or at least before discharge. We let tens of thousands of our young people out without an evaluation, and then we wait until they come to the VA. Maybe we do the evaluation better, but we still have hundreds of thousands of young people without ever being evaluated.

Dr. PETZEL. We would agree with you that screening while a soldier is still in the military would be best.

The CHAIRMAN. Do me a favor. Issue a directive not to use the word screening because—

Dr. PETZEL. Evaluate.

The CHAIRMAN [continuing]. U.S. Department of Defense (DoD) says they screen everybody and VA says we screen everybody who comes in. But a self-administered questionnaire is not an evaluation. I think they use the word screen advisedly and it is not sufficient in my view to screen somebody as opposed to evaluating them with a professional person.

I apologize, Mr. McNerney, for jumping in here, but I think it is the real single most important thing we can do for our young people is to have a mandatory evaluation.

Dr. PETZEL. We would agree. If I may, our biggest issue is the fact that we have only enrolled and seen 46 percent of these veterans who are returning from Iraq and Afghanistan. There is another 54 percent that we have not, in spite of our outreach efforts, actually been able to see. So our biggest issue is that we are not able to evaluate a large percentage of the veterans from Iraq and Afghanistan.

I am comfortable that, we have a very good case management program for the severe traumatic brain injury patients that pass through our TBI centers and for the moderately and mildly injured patients, but there are people who fall through the cracks. There are individuals, and I am sure that you probably have an example or some examples of people who have not been case managed well by us, which we would obviously like to hear about. We have a very extensive outreach program and a very extensive case management program.

Mr. MCNERNEY. Well, we talk a lot about the seamless transition from the DoD to the VA. Is there some way that that could be used to make this more effective in reaching those 54 percent that you are not able to get through to?

Dr. PETZEL. That is a very good point, Congressman. Once the soldier leaves their unit, their interest obviously is getting back to their families, getting back to their jobs, et cetera.

With the National Guard, we have the opportunities to go to their Guard centers and we do. We have Beyond the Yellow Ribbon Program which is very effective in getting to the Guard and alerting them about potential problems they may have, and the kind of services that are available.

We are doing a better job with the Reserve now, too, because they again go back to a unit that we can visit.

The most difficult group of people are the active-duty service-members who are discharged, go back to their community, and are not in a setting where they gather that we can reach numbers of them at one time.

The DoD has an excellent program to reach out to them in conjunction with us, but I would say that is the most difficult group that we have.

And, again, as the Chairman has suggested, screen at the time of return before discharge, evaluating at the time of return would be an effective thing to do, I think.

Mr. MCNERNEY. Okay. Thank you.

I am going to yield back, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Stearns, you are recognized.

Mr. STEARNS. Thank you, Mr. Chairman.

Dr. Petzel, there was a July 2008 hearing on miscellaneous expenditures, inadequate controls at the VA. The U.S. Government Accountability Office (GAO) testified that the VHA recorded over \$6.9 billion in miscellaneous obligations during fiscal year 2007. These obligations were for fee-based medical services, drugs, medicine, and transportation of veterans. I understand this amount has increased.

GAO looked at 42 case studies and all 42 cases lacked documented oversight by contracting officials. VHA reacted by issuing new guidance on the use of miscellaneous obligations in 2008. GAO stated that without basic controls over the billions of dollars that the VHA is spending in miscellaneous obligations, and I quote, "VA is at significant risk of fraud, waste, and abuse."

The two OIG reports released this past Monday indicate very little improvement over the past 2 years. I think VA is in deep denial that procurement reform is in the VA, specifically in VHA was broken and is severely vulnerable to billions of dollars in fraud, waste, and abuse today.

Do you agree?

Dr. PETZEL. Congressman, I agree that there were serious problems with acquisition. I believe that it is absolutely essential that we professionalize our acquisition and technical contract oversight group.

The Secretary has taken this on as a fundamentally important part of his transformation. And just to go through some of the details that have occurred, the administrations, and I speak particularly about VHA, has centralized its contract administration. The contracting officers do not now report to the VISN or to the medical center. There is a central administration of contracting.

They have added a very strong compliance and a very strong review process and personnel to the contract offices. We have literally hired in the last 6 months and are continuing to hire hundreds of people to staff the oversight staff, the compliance, and to beef up our contracting personnel.

I am quite confident speaking today that once we have these people hired and once we have the oversight groups in terms of quality assurance and compliance up and functioning, you are going to see

dramatic improvements in our administration of the miscellaneous expenses and in the contracts that we have.

Mr. STEARNS. You say once they are hired. When do you think they will be hired?

Dr. PETZEL. I am sorry, Congressman. I cannot say exactly when. I know we have already hired over 100 new people and have authorized the hiring of an additional 100 people. So by the end hopefully of this fiscal year, we will have hired at least 200 of these new individuals.

The CHAIRMAN. Could you yield for a second?

Mr. STEARNS. Sure.

The CHAIRMAN. When you answered Mr. Stearns, the first beneficial thing you said was centralization. I understand that in terms of legal issues and oversight but the OIG suggested that the provider may have some more insight to that or has some direct health concerns rather than a monetary concern. It also happens with IT.

Mr. Baker, I think you know there is a sense in the hinterlands that centralization in some of these areas is obviously very important for reform. But if it overrules local expertise for no other reason than the fact that it is efficient in the Central Office, that is also a problem.

How do you balance that both in the area—you are not the acquisition guy—but—

Dr. PETZEL. Mr. Chairman—

The CHAIRMAN [continuing]. The local guy versus the central guy, how do you balance that stuff?

Dr. PETZEL [continuing]. I can certainly speak about the clinical implications of this. The issues that involve the practitioners, the pharmacists and the physicians, are what are you going to purchase. The example in the OIG's report that I think is an excellent one, if you will pardon me for spending a moment with it, is the surgical implants.

There were three items that were mentioned in that report, coronary artery stents, aortic grafts, and aortic valves. Coronary artery stents, the issues about what stent you put in are not particularly controversial.

We, for the last 2 years, have been trying to get bids on a national contract. We would love to have a national contract with stents. We spend \$59 million a year and there is general agreement that we could do this amongst the cardiologists, but no provider has taken us up yet on that. We are out with another RFP and we will see if we can manage to get that procurement completed.

Aortic grafts and aortic valves are far different. We use very few of them, 150 aortic grafts a year and about 1,500, which is not very many, aortic valves per year. In those instances, it is felt that the practitioner choice is very important, that the clinical circumstances within the aortic valve vary tremendously from patient to patient. The surgeon needs to be able to get the valve that they want.

The same thing with aortic grafts. They are very infrequent and the surgeons again feel they need to get what they want. Plus the fact that the volume is so low that we are not talking about saving a tremendous amount of money.

So in that instance, we have recommended, we have said back to the OIG that we are not going to get a national contract in either one of those areas, but we are going to ask or allow the practitioners to pick and choose what they want.

That, Mr. Chairman, is an example of how the practitioners get involved in this acquisition process to make sure on the one hand their needs are met and on the other hand we are doing the fiscally responsible thing.

Mr. BAKER. If I could address the IT side of that, Mr. Chairman, just quickly. One of the things that we have lots of great private sector examples on IT, the infrastructure, the networks, the e-mail system, the security are best done from a central perspective and very uniformly. But customer service like politics is a local thing. It is the person that comes to see you. It is the person you can see and hold directly responsible for whether or not your services are getting done.

And we have really tried to have that focus inside of the Office of Information and Technology here for the last year. It is really focusing on customer service for our clients at VHA, VBA, and the rest of the corporate folks.

Mr. STEARNS. Mr. Chairman, thank you.

Dr. Petzel, I have two reports here. One is dated June 7th and the other one is June 7th also. These are two VA OIG reports that were released, of course, this last Monday. Both deal with flawed VA procurement practices.

If you do not mind, let me just quickly, Mr. Chairman, highlight some of the findings.

Contracting officers did not ensure adequate competition, maximize use of the Federal supply schedule instead of local contracts, or maintain required contract documentation.

Medical facility staff made unauthorized commitments.

The Procurement and Logistics Office lacked an effective oversight process for health care staffing and service procurements.

There was lack of guidance and training, which made procurements more vulnerable to improper payments, higher prices, and Federal acquisition regulations deficiency.

And, finally, 77 percent of the audited procurement orders had not been adequately reviewed and 51 percent had ordering and competition issues.

Were you aware of these two reports that came out on June 7th?

Dr. PETZEL. I saw them on Monday, June 7th, Congressman, when they came out.

Mr. STEARNS. Were they a surprise to you?

Dr. PETZEL. No, they were not.

Mr. STEARNS. So a lot of this information you knew how long ago?

Dr. PETZEL. I cannot tell you, Congressman, exactly how long ago, but we make the responses to the OIG recommendations, so we have seen the reports previously.

Mr. STEARNS. Okay. Of the different findings, is there any one that you think can be solved immediately? All of these go into you once we have sufficient people, will we be able to solve them, or otherwise, will this continue?

Dr. PETZEL. No, I do not think we need to wait until we have sufficient people, Congressman.

Mr. STEARNS. You know, I mean, if I got this and I was operating a corporation, as soon as I got this, I would implement a special task team, ad hoc Committee to go right at it and solve the problem. And I would be able to say to my board of directors or shareholders who also got a copy of this report, I would say to them I hope to have this solved within 6 months to a year, but I will get back to you in 90 days what I am going to do.

Is that a reasonable request on you?

Dr. PETZEL. Oh, absolutely.

Mr. STEARNS. Because the amount of money you are talking about is enormous and here you have these two reports. You have a copy of them. I just outlined some of the problems. And each of these areas would mean huge amount of savings which we could use for better care of our veterans.

Dr. PETZEL. Let me describe the process.

Mr. STEARNS. Well, let me just ask you a question. Do you think it is reasonable to ask—I mean, it is possible that if I was Chairman, I would ask you on these reports to maybe call me in 90 days and say what you have done. Is that a reasonable request?

Dr. PETZEL. Absolutely. We do ourselves 30-day, weekly, 30-day, and 90-day updates on what is happening with each one of the recommendations. We are required and we do report back every 90 days to the OIG.

Mr. STEARNS. What about to Congress who appropriates the money for you? Do you tell us what you have done?

Dr. PETZEL. Sir, to be honest with you, I do not know what the process is—

Mr. STEARNS. Okay.

Dr. PETZEL [continuing]. With Congress. I will find out.

Mr. STEARNS. Well, you know, staff just pointed out to me that there was a July 2008 hearing on these very items, miscellaneous expenditures and inadequate controls. So that was 2 years ago and evidently the reports that have come out from the Inspector General have just reiterated what we discussed 2 years ago in a VA hearing.

Were you aware of that July 2008 hearing on miscellaneous expenditures?

Dr. PETZEL. I was not.

Mr. STEARNS. You were not. Does anybody on your staff know about those hearings?

Okay. Were you in the Department 2 years ago?

Dr. PETZEL. I was in the Department, not in this job.

Mr. STEARNS. Not in this job. Who was in the job that you have in 2008?

Dr. PETZEL. Michael Kussman, Dr. Michael Kussman.

Mr. STEARNS. Okay. So Michael Kussman must have known about this and this hearing, so all these expenditures, miscellaneous expenditures were talked about. It was revealed there is inadequate controls at the VA. So 2 years later, there is nothing changed because we have two reports that came out June 7th and we are talking about pretty much the same items.

What does that tell you?

Dr. PETZEL. Congressman, that tells me that there was inadequate followup and followthrough on the recommendations that were done before, inadequate education, perhaps inadequate staffing, and those, I am sure, are part of the responses to or are part of the responses to the recommendations.

Mr. STEARNS. So what you need to do is convince us here on the Committee that your response is not going to be like the response of your predecessor.

Dr. PETZEL. I can assure you, Congressman, that that is the case.

Mr. STEARNS. Okay, Mr. Chairman, would you like to comment?

The CHAIRMAN. I think we need a followup on the issues you are raising here, just on procurement. As you know, the Secretary is making a suggestion for a new Under Secretary for Procurement. Perhaps we can follow up on your questions with the Secretary and this Deputy in a separate hearing that I think we need to have on procurement issues.

Mr. STEARNS. I think that is true and I think also that Dr. Petzel should send a letter to the Committee with the assurance that what occurred 2 years ago will not reoccur and perhaps give you an update of what he is doing.

The CHAIRMAN. Yes. Correct me, Mr. Stearns, was this directly in the Veterans Health Administration?

Mr. STEARNS. It was. I am told by staff it was.

The CHAIRMAN. Okay, because Dr. Petzel is not directly responsible for procurement and maybe we should have had the Deputy Secretary here for that. I think we need to focus in on those issues with the people who have to deal directly with them.

Mr. STEARNS. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. I appreciate you bringing those up.

Just as a followup to what Mr. Stearns was talking about, and this is directly in VHA, there are reports still open from the OIG, one from September of 2008 that says an audit of VHA noncompetitive clinical sharing agreements would have a potential savings of \$60 million. Apparently, we have not had the response within the year.

Are you aware of that report?

Dr. PETZEL. I am aware of that, Mr. Chairman.

The CHAIRMAN. What is going on?

Dr. PETZEL. My understanding is, and I reviewed all 23 of the outstanding recommendations that we had seen in the semi-annual report, and that group associated with that particular acquisition process all revolved around the training of our acquisition staff.

There is a relatively newly established acquisition academy to which everybody has to attend and the curriculum was written around the recommendations in that OIG report. The OIG will not close that recommendation out until we certify that every single acquisition individual has been through that training program.

The CHAIRMAN. I see. But you have—

Dr. PETZEL. Absolutely.

The CHAIRMAN [continuing]. Eventually reacted to it. Mr. Michaud?

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Dr. Petzel, last month, this Committee held a hearing on the status of the National Vietnam Veterans Longitudinal Study. Several

Members of the Committee expressed concern that the VA has taken so long to finish conducting the study due to problems related to VA's acquisition process.

While I am pleased that the VA has since released a request for proposal on May 25th for this effort and expects a contract to be awarded by the end of the year, I am concerned about the overall number of open recommendations that VA still has not implemented and that even once the study is finally completed, VA will have even further delays in implementing any recommendation that results from this study.

What plans does the VA have to ensure that this does not happen?

Dr. PETZEL. Well, first of all, Congressman Michaud, I share your concern about the delay. This harkens back to 2005. And just to reiterate a bit of that history, we found that we had difficulties with the contractor and eventually have come to the point of writing a new Request for Procurement (RFP) which, as you pointed out, was just issued on the 25th.

I think a number of lessons have been learned from that. One is that the RFP that has been written this time is a much tighter document and I think it is going to allow us to find a better contractor for that study.

Those veterans deserve that longitudinal study. There are many issues in their minds that surround the experience in Vietnam and I think that this study is a very important part of the ongoing evaluation of the health effects that might have been associated with Vietnam.

So, number one, I think we have a better RFP. Number two is we are going to have a much tighter process of monitoring the performance in that contract than existed previously now that we know about the difficulties with that kind of a study and the kinds of issues.

So I can promise you that we will keep much better track of what is happening with that contract in the future.

Mr. MICHAUD. Thank you very much.

My second question is, the OIG talked about the two reports on reusable medical equipment and indicated that at the August 2009 followup review that 129 facilities were compliant with respect to standard of operation procedure and 128 had appropriate documentations of demonstrated competence.

Yet, in March of this year, the OIG issued a report about reusable medical equipment problems at three sites in Puerto Rico. And my concern is, you know, with this report dealing with Puerto Rico, you know, once we—it appears that we are solving some problems.

How can these things happen, especially since they are just recent?

Dr. PETZEL. Congressman Michaud, another good question. We have noticed in the CAP reports periodically as with Puerto Rico that there are sometimes relatively minor but definitely issues with reusable medical equipment. A placard is not posted in the correct place. There is not good documentation of training, et cetera.

I believe that this is a result in part of the fact that we have not yet completed our response to this larger issue across the country. There are two aspects to that.

One is that we are industrializing the process of cleansing and sterilizing reusable medical equipment, turning it into not a medical process, but into an actual industrial grade or level process using the standards of what is called ISO 9000, which is a set of industrial standards used in many different manufacturing processes. That effort is underway, but is not yet complete.

A corollary to that is that we are setting up a national compliance and oversight program for reusable medical equipment where we have a separate group of people that will be responsible for seeing that the rules, et cetera, the directions, the directives are being followed.

And then the third thing is that we are standardizing our reusable medical equipment. At the time that we first began looking at colonoscopes, there were probably 30 to 40 different kinds of colonoscopes around the country. In an individual medical center, it could be 20 or 25. We are asking a group of technicians to be facile with 25 different cleaning instructions for colonoscopes. So that is not reasonable and that is not good practice.

We are in the process of getting RFPs and going out to develop standardized national contracts and we will ask that the medical center have no more than, let us say, ten, I am not sure what the number will be yet, but ten scopes so that we can be sure that there is a minimum stress on the part of the people cleaning these scopes to learn a large number of different processes.

So those two efforts, I think, are going to eventually lead us to the point where we will not be seeing these isolated incidents in the CAP reports as you pointed out.

Mr. MICHAUD. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Dr. Roe?

Mr. ROE. Thank you, Mr. Chairman.

Just a couple of questions to dovetail with Mr. Michaud's points. You said there were, in some institutions, 25 different colonoscopes?

Dr. PETZEL. There could be that many, correct, Congressman.

Mr. ROE. Hmm.

Dr. PETZEL. Different models perhaps in some instances of the same scope, but absolutely.

Mr. ROE. Yeah. I mean, it would not be 25 different procedures to clean a scope with a minor variance. I mean, that—

Dr. PETZEL. Well, each one of those scopes, Congressman, could have different cleaning instructions. If it is a different model of the scope, the cleaning instructions can be different. So, yes, it is possible.

Mr. ROE. I will have some more information on that later. I am not so sure about that.

The Chairman made a great point a minute ago when he mentioned about new innovations that would come along, and I know this is not your area of expertise on procurement, but where you would have a central procurement here. And I could understand where if you are looking at IV fluids or band-aids or whatever it might be that are pretty generic, that are pretty standard, whether

you have D5 lactated ringers made by somebody and somebody, I get that. But his point was a little more specific.

And what the OIG was saying a minute ago is very true is that when you get down to the individual patient and you are taking care of that person, you want whatever it takes to give quality of care to that person and as a more centralized issue, I mean, procurement may not work for an individual person.

How does the VA, and I heard you say about the aortic valves and the micro valves, but I hear this a lot at the VA about when you—by an individual practitioner, I may not have this particular medicine or that particular device, for instance, orthopedists use a lot of different knee devices or shoulders or fingers or whatever it may be, how do you do that?

And I worry about that because I have worked in a hospital where a central supply tries to buy something for me that I am trying to use in the operating room and they could not tie a knot if they had to. So it does make a difference when you are in the operating room using a device or piece of equipment that you are familiar with, you know that works, and you get good results with.

Dr. PETZEL. Congressman, as you pointed out, there is a tension between the desire to have some standardization and provide as much value as you can for whatever it might be you are purchasing on the one hand and on the other hand, the individual particular desires of a practitioner.

Orthopedic surgery is an excellent example of that. Orthopedic surgeons tend to use the equipment that they were trained on. It does not mean that one piece is better than the other piece. It happens to be the piece that they are familiar with.

The question is, how far do you go in compromising the individual person's desire to have the kinds of equipment that they trained on versus the need to add value by being cost effective.

Mr. ROE. Let me give you an example. I do not have much time. Let me give you an example. We were able to buy some new laparoscopic equipment that was expensive. It was about \$2,000 for one piece of equipment. But we cut our operating time on a laparoscopically assessed vaginal hysterectomy from 3 or 4 hours to an hour.

Is that worth doing? Did patients benefit? Absolutely. Would it have made sense economically? I do not know, but I know the patients certainly benefited from it.

Dr. PETZEL. I can tell you it would have made sense economically because if it cuts an hour off your operating room time, that means you can use that operating room more efficiently. That is the kind of decision that we would endorse.

Mr. ROE. I think the other issue that the Chairman brought up very well was his example about diabetes. And I realize those are not real facts, but how do you evaluate that? And I agree with him completely. How do you evaluate that? You can take the dollar pill or you can take something more expensive, but may be better and the benefits may be down the road.

Dr. PETZEL. That is again a very good point, Congressman and Chairman. You both have raised it.

The key to that in my mind is comparative effectiveness trial. That is, these two ways of treating diabetes need to be evaluated

side by side. If the expensive drug proves to be substantially better than the inexpensive drug in managing a diabetic, then it will become the drug of choice.

Cost cannot be and is not ever the only thing that is being considered. You need to look at the medical literature, you need to look at the comparative effectiveness studies and make a decision about whether or not the advantage of this drug, if there is any, outweighs the cost of that particular drug.

Mr. ROE. But is that being done? I mean—

Dr. PETZEL. Absolutely. Absolutely.

Mr. ROE. Okay. Could we see that here because I think that is very important?

And just before I yield back, thank you, Mr. Chairman. I know my time is expired. On your point on PTSD, I think an evaluation should be mandatory when you get out, not just a questionnaire, and then continue to evaluate these folks. And I think what the OIG said, because I know from my own experience as a veteran, some of those issues are dealt with then as a young man, a 25-, 26-year-old Army Captain, you are still dealing with now later. And some of these things amplify, and that is what PTSD basically is. You see a lot of folks that are having a very difficult time later in their life dealing with issues that happened to them three decades ago.

So I think that is a good point, but to continue to do that, and outreach, I think I heard maybe it was you or the OIG say is it is difficult to find these folks that are regular Army or Navy, whatever, career military folks that do not have a way to get back to them.

Dr. PETZEL. Right.

Mr. ROE. Okay. Thank you.

I yield back.

The CHAIRMAN. Mrs. Kirkpatrick?

Mrs. KIRKPATRICK. Thank you, Dr. Petzel, for your testimony today and for answering our questions.

I am going to ask you about the Fiduciary Program. We recently had a Subcommittee hearing about the program that raised some substantial questions in my mind about the oversight of the fiduciaries.

You know, with the increased incidence of TBI and severe PTSD, apparently more and more veterans are needing fiduciaries to help them handle their money. And I think the fact that they need this help makes them among the most vulnerable of our veterans.

So I was troubled when I saw that the OIG's 2006 audit made recommendations to the Fiduciary Program and then 4 years later in 2010, there were similar problems.

And so I wondered if you could explain to me why those recommendations were not implemented in that 4-year time period.

Dr. PETZEL. I would like to turn that question, if you do not mind, over to my colleague from VBA, Ms. Rubens.

Ms. RUBENS. Yes. Thank you. I appreciate the opportunity to address this.

I cannot tell you how much I agree with you in terms of the special needs our veterans have when they come back with that TBI or been determined to be incompetent perhaps later in life.

That 2006 OIG report troubled me when I was out in the field. And as I did my homework after now being here to say, okay, why have we not finished implementing these recommendations, particularly as they pertain to appropriate levels of staffing. And, in fact, after the OIG study had come out, VBA did go out and engage a contractor to help us take a look at what are the work measurement issues around managing that program to ensure we actually are providing enough oversight.

Quite frankly, the initial study that was done was found to be, if you will, inadequate in terms of the findings. The recommendations were sort of scattered. As we began to look at validating, if you will, their approach and their findings, P.L. 110-389 was passed which required an overall work measurement study within the Compensation Program.

So, okay, we are going to shelve the first one. We are going to take this second study on. And, in fact, that study was done and the results of it as we worked with the contractor to review what they had come up with were largely qualitative. They were not quantitative in terms of beginning to lay down some real hard data in terms of how many incompetent veterans requires what level of oversight.

Given that I will call it disappointing outcomes on two studies, we are taking that information and putting together an internal review. And before the end of this fiscal year, we will have recommendations on what is the appropriate level of oversight to provide to our Fiduciary Program.

Mrs. KIRKPATRICK. Thank you. That is good information. I am pleased to hear that you have a specific timetable for completing that.

Let me ask you, is there, in the recommendations, I have not seen them, I would like to see them, but is there a recommendation that all the fiduciaries be certified or have a certain standard of training?

Ms. RUBENS. You know, I am not sure if that is within the recommendations. I would tell you that VBA has begun to work to establish, if you will, a more professional workforce overall. There are some standardized tests in place as a result of the training programs for our veteran services representatives. We are also developing those studies and test instruments for the knowledge base and ability to provide the benefits for both our rating veteran service representatives, our decision review officers.

We have strengthened the expertise in our Compensation and Pension Program and are building a much more robust training program and we will look to engage that certification program for both our legal instruments examiners as well as our field examiners who have real responsibility for our incompetent veterans in the Fiduciary Program.

Mrs. KIRKPATRICK. Well, thank you for your attention to this. I think it should be a top priority. And I will look forward to the report later on this year. Thank you.

Ms. RUBENS. Terrific.

The CHAIRMAN. Thank you.

Dr. Petzel, thank you for your presence here.

You heard me ask a couple questions which are sort of off the subject, but we referred to them again as in the formulary determinations. And you were very confident about the process. I am not sure about that process. I do not know who makes those decisions.

I will give you a chance to say some more, but I want to give you a heads up. We are going to ask the Secretary and yourself to look at certain decisions that were made that seem to neglect, one, the long-term cause versus the immediate cause and, second, maybe more importantly, I will say quality of life issues that are hard to quantify.

This diabetes situation I brought up, which was basically, by the way, a factual situation, I may have the numbers or the numbers were not exactly accurate, but to take a shot once every 2 weeks instead of twice a day, how do you measure that? And, yet, I mean, if it was up to me, I would go to the 2-week one.

How is that considered in the formulary determinations and effectiveness? I mean—

Dr. PETZEL. Congressman, I would absolutely agree with you. If that were I and I were diabetic, I would want the shot every 2 weeks as opposed to every 1 week or every day obviously.

I cannot tell you specifically the inner workings of the Pharmacy Benefits Management Board, which is the group that looks at these nationally and makes these decisions, but I would welcome the inquiry.

The CHAIRMAN. I think I would like to bring some examples to you and the Secretary to see how that decisionmaking is considered good. Maybe there is a reason for it, but maybe not. I just want to give you a heads up that we will be looking at that.

Dr. PETZEL. Thank you.

The CHAIRMAN. When I said innovations, just one sticks in my mind where a Food and Drug Administration (FDA) approved technology for TBI victims that would expand the field of vision from a few percent to 50 percent and gives that patient the chance to read. This would be an incredible increase in the quality of life, right? And, again, FDA approved the technology and the manufacturer could not get past the acquisitions staff at VA. This is what we are dealing with that. That is just the one example that sticks in my mind. But, I would multiply those examples.

I think we are going to bring a bunch of these situations to you and the Secretary. Technology changes so quickly, and it can be hard to evaluate but when these smaller innovative companies come to the VA with new processes, new techniques, new technologies, they seem to be met with a bureaucratic lull. We will be looking at the process.

Dr. PETZEL. Well, we would be delighted to, in these specific instances particularly, to respond to you about how we have evaluated a particular drug or particular technology. I think that would be an excellent dialogue to have.

The CHAIRMAN. By the way, on the formulary, you said it is in pharmacy. You mentioned some department.

Dr. PETZEL. Well.

The CHAIRMAN. Is that directly under the VHA?

Dr. PETZEL. Yes, that is in the Veterans Health Administration. We have a Pharmacy Benefits Management Board that looks at the national formulary.

The CHAIRMAN. Is that sort of self-contained, or do you know? You do not interfere in that or—

Dr. PETZEL. Absolutely not.

The CHAIRMAN. See, that may be what's wrong. You want independence but on the other hand, if they are the shopkeepers and one costs \$50 and the next one costs \$1, we will take the one that is less expensive.

Dr. PETZEL. There is a process, Mr. Chairman, by which in theory any practitioner can get any drug they want by making a request to purchase something or have something dispensed off formulary. There is a very clearly mapped out process by which one goes through. You would be quite surprised, I think both of you would be, at the number of off formulary drugs that we do use.

The CHAIRMAN. Maybe the practitioner does not even know about it though. Part of what the VA should be doing is looking for this stuff and working to help.

I think this is the first time you have testified before the full Committee.

Dr. PETZEL. It is, sir.

The CHAIRMAN. I want to say I appreciate your testimony. I appreciate the way you handled the questions. I appreciate your expertise and your willingness to work with us.

Mr. Baker, you all were good witnesses as well and we appreciate that. We usually do not say that to folks. We look forward to working with you and we thank you for being here.

This hearing is adjourned.

Dr. PETZEL. Thank you, Mr. Chairman.

[Whereupon, at 12:03 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Bob Filner, Chairman, Committee on Veterans' Affairs

The Department of Veterans Affairs Office of Inspector General plays a critical role in ensuring proper and efficient oversight of the Department's activities.

In the first half of fiscal year 2010, from October 2009 to March 2010, the OIG issued 120 reports, identified nearly \$673 million in monetary benefits, and conducted work that resulted in 232 administrative sanctions.

It is evident by these numbers that the high quality of OIG's work is essential in rooting out fraud, waste and abuse within the VA.

Today, we will examine the progress that the Department of Veterans Affairs is making in complying with the OIG's recommendations.

Currently, the Office of Inspector General has a total of 115 open reports with almost 694 open recommendations that have yet to be implemented by the VA.

The OIG's target date for implementation of these recommendations is within a year of publication.

Although most of these open recommendations are on track to be completed within the 1-year timeframe, 16 reports containing 45 open recommendations are over 1 year old.

Additionally, recommendations on VA information security issues tracked by an independent auditor show that there are almost 40 open recommendations, 34 of which are carried over from prior years.

The timely implementation of these recommendations is crucial to ensuring our Nation's veterans receive the best care. Many of these recommendations play a critical role in ensuring patient safety and safeguarding veterans' information.

Additionally, timely implementation not only reflects good management, but it always reflects a responsible use of taxpayer money. The monetary benefit yet to be realized by these recommendations going unimplemented is almost \$92 million.

During the country's difficult financial time brought on by the recession, the VA must realize cost savings anywhere practical. This can be done straightforwardly through the elimination of waste and by acting to correct the issues identified in the OIG's recommendations in a timely manner.

The Office of Management and Administration's Operations Division is tasked with followup reporting and tracking of OIG report recommendations while ensuring that all allegations made by the OIG are effectively monitored and resolved in a timely, efficient and impartial manner. I am pleased that they are here today with Deputy Inspector General Griffin to share with the Committee their insights on this issue.

The OIG's reports for followup procedures are an essential component of the oversight process. Secretary Shinseki has said many times before this Committee the importance of accountability and ensuring veterans' care comes first.

The VA must be held accountable for implementing the OIG's recommendations in a timely manner, and make certain our Nation's veterans are receiving the quality of care that is reflective of their service and sacrifice.

Prepared Statement of Hon. Jeff Miller, a Representative in Congress from the State of Florida

Thank you, Mr. Chairman.

The existence, and independence, of the Office of Inspector General is an incredibly important tool in not only helping VA identify shortcomings but also to help us here on this Committee do our job more effectively.

Maintaining the OIG's full capabilities is of importance to all of us here, and that starts with the budget process. As that office identifies areas of redundancy, poor performance, or potential cost-savings, I see no reason to flatline or even cut its

budget. As the authorizing Committee, this is one step we can take every year toward doing our part.

VA has acted on an overwhelming majority of IG recommendations, in accordance with their standardized process. That much I am glad to see.

What I hope others on this Committee share with me is concern about the lack of action on IG recommendations that have been open over a year. The total number of recommendations as a percentage might be comparatively small, but as an actual number are high.

These recommendations aren't simply ways for VA to cut costs or eliminate waste, fraud, and abuse. They are potential ways to better deliver services to veterans across all departments within VA. That objective cannot—and must not—be overlooked.

I look forward to today's testimony about VA's implementation of the OIG's recommendations, and, in cases where there has been no implementation, to hearing the reasons why. VA, its Office of Inspector General, and this Committee can make great progress together, and this hearing is one step in making that progress.

I yield back.

**Prepared Statement of Richard J. Griffin, Deputy Inspector General,
Office of Inspector General, U.S. Department of Veterans Affairs**

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 FOLLOWUP PROGRAM

Followup 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 followup 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 followup request is sent to the responsible VA program office 90 days after the report is published.

In each followup 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 followup 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 followup 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 FOLLOWUP OVERSIGHT REVIEWS

The OIG also conducts followup 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 health care 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 followup 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 servicemembers 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—Colonoscopy 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 followup inspection 2 months later provided results for all facilities not previously inspected and for facilities previously found to be noncompliant with VHA's directive on RME reprocessing. Among the 129 facilities inspected in August 2009 during our followup 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 three 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 followup 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.

**Prepared Statement of Hon. Robert A. Petzel, M.D.,
Under Secretary for Health, Veterans Health Administration,
U.S. Department of Veterans Affairs**

Good morning, Chairman Filner, Ranking Member Buyer, and Committee Members. Thank you for the opportunity to appear before you today to discuss the Department of Veterans Affairs' (VA) work in responding to recommendations from the VA Office of the Inspector General (VAOIG). Joining me today are Roger Baker, Assistant Secretary for Information and Technology, and Diana Rubens, Associate Deputy Under Secretary for Field Operations for the Veterans Benefits Administration (VBA).

The scope of VA's missions extends far beyond the provision of health care to include providing educational benefits so veterans can receive the knowledge and skills to continue serving the needs of a 21st century America; processing compensa-

tion and pension claims in our regional claims processing offices; and showing the utmost respect for veterans and their families at the end of life in our national cemeteries. For example, VA:

- Provides educational benefits of \$9 billion annually, second only to the amount provided by the Department of Education.
- Guarantees nearly 1.3 million individual home loans with an unpaid balance of \$175 billion. VA foreclosure rate is among the lowest in all categories of mortgage loans.
- Insures veterans' lives as the Nation's eighth largest life insurance enterprise with \$1.3 trillion in coverage, 7.2 million clients, and a 96 percent customer satisfaction rating.

To accomplish its diverse mission, VA employs more than 300,000 people—the second largest department in the Federal Government. The standard for each employee who works at one of our facilities is to be fully aware of and committed to our mission to serve veterans. I trust that every employee, up to and including our leadership, strives to meet that mission daily with the utmost professionalism and integrity.

However, improvement is also a goal. With that in mind, VA recognizes the VAOIG's valuable work as our partner in ensuring accuracy, integrity, and accountability in the delivery of benefits and services to our Nation's veterans. VA is committed to doing everything possible to ensure that it is delivering the best possible service to our veterans, and we also recognize the value of working with VAOIG in our current "check and balance" system to ensure that we are being as effective and efficient as possible. Additionally, VAOIG's work helps VA to identify areas of waste, fraud, and abuse, as well as to remove persons whose conduct is truly criminal. This not only improves our operations as a Department in providing services to our veterans, but it saves the American taxpayer millions of dollars every year.

The scope of the VAOIG's work is immense and far-reaching, as its investigations can be specific to facilities, or result in broad reviews of VA programs. Its reports have resulted in hundreds of recommendations for the Department, ranging from administrative actions against specific personnel to large-scale policy reviews. Additionally, the Department and VAOIG maintain a strong relationship in identifying, investigating, and bringing to justice those who use their positions to defraud or harm our veterans.

In order to provide timely and appropriate responses to VAOIG's recommendations, the administrations and staff offices involved with each report work directly with VAOIG to ensure that action plans are developed and implemented to result in positive change.

Veterans Health Administration

VAOIG conducts several different types of reviews of Veterans Health Administration (VHA) facilities and programs. VAOIG reviews:

- National programs through audits, broadly focused Healthcare Inspections, and other nationally focused reviews.
- Single VA medical centers or community-based outpatient clinics (CBOC) through Combined Assessment Program (CAP) reviews and individual CBOC reviews.
- Roll-ups of CAP reviews can summarize a number of findings from several facilities and include recommendations with a broader scope than a single CAP review.
- Healthcare Inspections can result from a nationwide or broad review initiated by VAOIG, an individual CAP review, or a finding after a review of an allegation made by a call to the VAOIG hotline. These Healthcare Inspections can be specific to a facility or involve a broader scope.

VHA has a standardized process to identify and respond to VAOIG recommendations from each type of review. Initially, once the VAOIG has issued a final report including recommendations and VA responses, VHA staff use its database (VHA Electronic GAO and VAOIG Recommendation Status System—EGORS) to track progress of closing recommendations. When VHA program offices submit reports about completing tasks that are part of an action plan, VHA records and reports that to VAOIG. Also, VAOIG requests a status update on the progress in closing a report's recommendations 90 and 180 days after the issuance of the final report. At these 90-day intervals, VHA communicates with program offices on the progress of the action plans previously submitted and documents the completion of any items, regularly reporting to VAOIG about the status of closing recommendations. This process is repeated until VAOIG closes all pending recommendations. If progress in

implementing changes is delayed, VHA leadership meets with the responsible office to expedite action and close the assignment. For recommendations that are open more than 6 months, the VHA Chief of Staff meets directly with the program office to review the status of closing a recommendation and does so monthly until the action has been completed.

For the more narrowly focused CAP reviews, VAOIG requests a status update from VHA 90 days after the issuance of the final VAOIG CAP report. This request is sent directly to the Veterans Integrated Service Network (VISN), the VA medical center, and VHA leadership in Central Office. The facility provides an update of its progress in completing the action plan included with the final CAP report directly to VAOIG and informs VHA leadership at the same time. VHA leadership tracks the facility's progress in implementing the action plan and communicates with the facility directly when there are delays or questions. This process is repeated until VAOIG closes all recommendations from a CAP. This same process applies to Healthcare Inspections that result from a CAP or a finding resulting from a review of an allegation made to the VAOIG hotline.

VHA leadership, including the Chief of Staff, the Office of the Deputy Under Secretary for Health for Operations and Management, the Office of the Principal Deputy Under Secretary for Health, and the Director of the Management Review Service, meet on a monthly basis with VAOIG leadership and staff to discuss ongoing and future reviews and how to continue improving communications. Less formal discussions between VHA and VAOIG are more frequent.

Veterans Benefits Administration

VBA takes very seriously VAOIG reports' findings and recommendations, and it works diligently to implement recommendations made in those reports to further strengthen benefit programs.

VBA works closely with VAOIG, Office of Audits and Evaluations and the Office of Management and Administration, to provide timely and accurate status updates on all open recommendations. VBA provides status updates to VAOIG every 90 days to describe the actions taken or in progress to fully address recommendations until they are satisfactorily closed by VAOIG. VBA tracks and maintains current information on the status and target completion dates for all open recommendations, and works proactively with VAOIG to reconcile data and address outstanding questions.

The VAOIG Benefits Inspection Division (BID) implemented independent inspections beginning in fiscal year 2009 to provide recurring oversight of VA regional offices by focusing on disability compensation claims processing and performance of Veterans Service Center operations. The BID's audits of regional offices include reviews of local claims processing, data integrity, management controls, information security, and public contact. These inspections incorporate claim file reviews, employee interviews, and management feedback. VBA leadership reviews and responds to the recommendations provided by the BID, ensuring errors are corrected and recommendations are implemented in a timely manner. The issuance of the audit report follows 60 days after the BID team conducts a site visit and all initial and followup responses to inspection recommendations are reviewed and concurred upon by the regional office, area office, and Office of Field Operations. Once these steps are completed, the BID determines the recommendation is implemented and the report can be closed. VBA currently has nine open BID reports of specific VBA regional offices.

While VAOIG's audit work in VBA is primarily focused on the compensation and pension program, VAOIG is also currently reviewing the implementation of the Post-9/11 GI Bill.

Office of Information and Technology

Upon receipt of VAOIG's status request, a notification is sent by the Project Coordination Service to the appropriate points of contact in the Office of Information and Technology (OI&T) staff office responsible for implementing the open VAOIG recommendation. The Project Coordination Service conducts followup reporting and tracking of VAOIG report recommendations to ensure implementation.

IT staff offices are directed to address each open recommendation individually, stating the progress made over the preceding 90 days and providing supporting documentation, if applicable. Their response also indicates whether OI&T recommends closing any recommendations. OI&T staff offices then prepare a soft and hard copy submission, to include background information on the IG report/recommendation, a signed briefing note, a memorandum for Senior Level Executive (SES)-level signature, and an attachment containing status updates.

All status updates are submitted to the Project Coordination Service for review no later than five business days before the VAOIG due date. Once the Assistant Sec-

retary for OI&T signs the memorandum, the response is sent to the VAOIG Operations Division, Office of Management and Administration.

Recommendations Open for Over One Year

The “Federal Acquisition Streamlining Act 1994,” P.L. 103–355, requires VA to complete final action on each VAOIG report recommendation within 1 year after the report is finalized. Although VA strives to meet this target, and does so for the overwhelming majority of reports issued, OIG has identified recommendations that have been open for over 1 year.

VHA Recommendations Open for Over One Year

VHA has eight VAOIG reports with 19 recommendations that have been open more than 1 year.

First, the “Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study (NVVLS)” has one of three recommendations still open. This recommendation involves initiating formal acquisition and planning and proper contracting processes to expeditiously and successfully complete the NVVLS and ensure that assigned project management and contracting staff have the required knowledge and skills to effectively plan, procure, administer and manage the NVVLS in accordance with pertinent legal, procedural and technical requirements. We acknowledge that deciding how to proceed with the NVVLS has been a long process. Since VA decided to re-initiate its work on NVVLS in late 2009, significant progress has been made, and I am pleased to report that VA released a request for proposals (RFP) on May 25, 2010, and expects an award will be made later this year. Details about the timeline are available in the testimony provided before this Committee on May 5, 2010. VAOIG has indicated it will close the recommendation when the contract award is made.

Second, the “Review of Access to Care in the Veterans Health Administration” report, issued in 2006, has two of nine recommendations that remain open. These involve standardizing tracking methods and appropriate performance metrics to evaluate and improve the timeliness of elective procedures as well as implementing prioritization processes to ensure that veterans receive clinically indicated elective procedures according to their clinical needs. Through VHA’s Surgical Quality Improvement Program (SQIP), VA is developing long-term information technology (IT) solutions, and in the interim has standardized appropriate tracking methods to improve the evaluation and timeliness of elective procedures. VHA has been advised that the IT solution will be implemented in early 2012. Also, VHA recently issued Directive 2010–018, “Facility Infrastructure Requirements to Perform Standard, Intermediate or Complex Surgical Procedures” in May 2010, requiring each facility to establish a transfer policy based on clinical need. VHA is currently working with VAOIG to close these recommendations based on these recent and ongoing actions.

Third, the “Review of the Acquisition and Management of Selected Surgical Device Implants” report from 2007 has one recommendation still open. This recommendation directed VHA to evaluate aortic valve, coronary stent, and thoracic graft procedures to study the feasibility of establishing national contracts and blanket purchase agreements (BPA) and, where indicated, initiate national contracts and BPAs.

When OIG issued the recommendation, VHA had been actively seeking national contracts for coronary stents for 2 years; however, few existing manufacturers indicated a willingness to participate. VHA has continued to evaluate the procurement history for these products to identify possible targets for standardization.

This spring, a Request for Information (RFI) related to coronary stents was again sent to industry, and VHA expects to respond to the vendor’s questions mid-June as well as develop and distribute an RFP by the end of summer 2010. VHA acknowledges that based on the current surveys, the price of drug-eluting stents, on average, are likely to decrease by \$300–\$400 per stent, resulting in significant cost reduction for VA if the RFP process is successful.

In regard to aortic valves and thoracic grafts, VHA recently completed comprehensive reviews of the procurement history for these devices to determine if the use of national contracts or BPAs were feasible. The completion of these reviews has been time consuming to ensure that the analysis was complete and comprehensive.

For aortic valves, the procurement history does not support use of a national contract or BPA because of issues involving the complexity of the clinical decisions resulting in vendor choice, the variety and availability requirements of implant types (mechanical, bioprosthetic, etc.) in relationship to the complexity of the disease being treated, the relatively low number of devices implanted by VHA, and the established safety of the devices currently utilized.

Neither does the review of the procurement history related to thoracic grafts indicate that use of a national contract or BPA is recommended. This is based on the

overall low number of thoracic aortic grafts being implanted by VHA, the complexity of the disease process requiring a choice of available and emerging vendor products, and the established safety of the devices currently utilized.

This information is currently being shared with VAOIG to determine if it is sufficient to close the recommendation.

Fourth, the "Audit of Veterans Health Administration's Oversight of Nonprofit Research and Education Corporations" report from 2008 has four of five recommendations still open related to establishing oversight authority parameters for Non-Profit Corporations (NPC); defining minimum control requirements for NPCs and subsequently training NPC Directors about these requirements; implementing oversight procedures to perform substantive reviews of NPC financial and management controls to ensure NPCs fully comply with Federal laws, VHA policies, and control standards; and developing and implementing procedures to review, monitor and enforce NPC compliance with conflict of interest laws and policies.

To address these concerns, the Under Secretary for Health (USH) chartered the Nonprofit Corporation Oversight Steering Committee (Steering Committee) in 2008 to develop a plan to assess existing NPC financial and management controls and use that information to develop and implement future processes. The reviews were completed in December 2009, and a white paper has been subsequently issued. Also, legislation that would significantly change the operations of NPCs has been pending since early 2009. Congress passed legislation in April 2010, and Public Law 111-163 was enacted in May 2010. On May 7, 2010, in response to the new law, the VA Nonprofit Oversight Board decided to delay issuance of any pending changes to NPC practices so that the elements from Public Law 111-163 could be included. The USH has directed that issuance of a handbook to implement this legislation and respond to the VAOIG concerns will be completed no later than December 7, 2010. Also, the VHA Nonprofit Program Office is using the results of the reviews completed in December 2009 to guide its continuing review of NPC operations.

Fifth, an "Audit of Veterans Health Administration's Government Purchase Card Practices" issued in 2008 has one of four recommendations still open. Recommendation 2 directed VHA to provide approving officials refresher training on using the revised Approving Official Checklist to ensure cardholders maintain adequate documentation to support their purchases. On February 18, 2010, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) mandated that all purchase card approving officials receive this refresher training. Each VISN Purchase Card Manager was to submit written certification when the training was complete. VHA has received documentation that the training is complete, and it anticipates that OIG will close this recommendation.

Sixth, the "Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements" issued in 2008 still has all seven recommendations open. An action plan to close these recommendations was developed in September 2008; however, that action plan had to be amended in December 2009 to add a mandatory training component to ensure consistent implementation of new policies and procedures. The curriculum for this training has been developed and submitted to the VA Office of Acquisition, Logistics, and Construction's (OAL&C) Acquisition Academy. The Academy is currently working to contract the completion of the provided material into curriculum for instruction. The course is scheduled to be available in 2nd Quarter FY 2011.

In regard to Recommendation 5 that directed VHA to instruct the VISN contracting officers to initiate recovery of overpayments identified by the VAOIG audit, as appropriate, VHA has instructed its VISN contracting officers how to initiate recovery of overpayments identified by this audit, and VHA is compiling documentation of this process. To date, all VISNs have completed their audits, and VA continues to work to resolve questions about the overpayments.

Seventh, the "Audit of Procurements Using Prior-Year Funds for VA Health Care Facilities" issued in 2008 has two of seven recommendations still open. Recommendation 5 directed VHA to initiate appropriate administrative action against contracting officers who entered inaccurate contract award dates in the electronic procurement accounting system and later signed the contracts after they should have known the funds had expired. Recommendation 7 directed VHA and the Assistant Secretary for Management to develop plans to implement controls over obligation of expired funds in other VHA programs, projects, or activities. VHA has sent documentation to VAOIG showing administrative actions taken in nine VISNs in response to Recommendation 5; VHA believes this may be sufficient to close the recommendation. Concerning the other item, VHA is working with VAOIG to determine if data extracted from VHA's sources other than nonrecurring maintenance obligation during FY 2009 for FYs 2004 through 2008 is acceptable to close the recommendation.

The final report, "Combined Assessment Program Review of the VA Central Iowa Health Care System, Des Moines, Iowa" issued in 2009 has 1 of 13 recommendations still open. Recommendation 4 directed VHA to ensure that the System Director requires the identified safety, infection control and patient privacy deficiencies be corrected. VHA continues to communicate with VAOIG about whether the documentation submitted earlier this year is sufficient to close the recommendation.

The VISN has taken other actions to ensure the high quality of current safety, infection control, and patient privacy practices. For example, the VISN 23 Readiness/Annual Work Evaluation (AWE) Team surveyed the organization March 8–12, 2010. A primary purpose of the Readiness/AWE Team visit was to ensure that there was follow up and closure regarding previous findings by VAOIG, the Joint Commission, and others. Items cited in Recommendation 4 were reviewed by the team and considered compliant.

Also the Joint Commission surveyed VA Central Iowa Health Care System April 27 to April 30, 2010. No previous OIG recommendations were identified in the Joint Commission survey as noncompliant at the time of the survey.

We are working with VAOIG to verify that the VISN has implemented the system changes necessary to attain compliance, and that these changes are being sustained. The VISN currently reports ongoing compliance above the 90 percent level.

VBA Recommendations Open for Over One Year

VBA has one VAOIG report with two recommendations that have been open more than 1 year.

The VAOIG Audit of "Veterans Benefits Administration Transition Assistance for Operations Enduring and Iraqi Freedom Servicemembers and Veterans" was issued on July 17, 2008. Two of the eight report recommendations remain open and VA action is ongoing.

Recommendation 6 directed the Acting Under Secretary for Benefits to develop a mechanism to obtain the DD-214 information needed to identify discharged veterans who should receive outreach letters. The goal is to use separation data from the VA/DoD Identity Repository (VADIR) to systemically issue outreach packages to separating Servicemembers, replacing the current manual process that utilizes the Veterans Assistance at Discharge System. VBA is working with VA's Office of Information and Technology and the Department of Defense to address unresolved technical and data quality issues. VA anticipates resolving these technical and data quality matters by September 2010.

Recommendation 8 directed the Acting Under Secretary for Benefits to establish policies and procedures that require staff to provide special outreach to veterans who do not have a high school diploma or equivalent. Full implementation of this recommendation is dependent on the receipt of complete and accurate information from DoD's Defense Manpower Data Center (DMDC) through VADIR. VBA continues to work with the DMDC to resolve discrepancies in the data necessary to implement this outreach effort. VBA is also writing the procedures for field offices, which will allow for full implementation once the data issues are resolved and construction is completed for an electronic mechanism to assign and track field outreach activities for this target population.

OI&T Recommendations Open for Over One Year

OI&T has one VAOIG report with one recommendation that has been open more than 1 year. The report, "Review of Issues Related to the Loss of VA Information Involving the Identify of Millions of Veterans," was issued on July 7, 2006. Recommendation 1d directed the Secretary to ensure all position descriptions (PD) are evaluated and have proper sensitivity level designations, that there be consistency nationwide for positions that are similar in nature or have similar access to VA protected information and automated systems, and that all required background checks are completed in a timely manner.

As a result of the recommendation, the Department has worked diligently to implement use of the U.S. Office of Personnel Management (OPM)-developed Position Designation System and Automated Tool (PDAT). The PDAT assists VA human resources specialists, managers, and security specialists to designate position risk levels for PDs. The PDAT has been in use since March 2009. Many VA organizations have used the PDAT to review current PDs and the PDAT is used for new PDs. Although the PDAT and the resultant new business processes meets the intent of recommendation 1d, the recommendation remains open pending issuance of VA Directive 0710, "Personnel Security and Suitability Program." The VA Office of Operations, Security, and Preparedness (OSP) was tasked with authoring the Directive, which has been approved by the Assistant Secretary for Operations, Security, and Preparedness. The Directive was signed on June 4, 2010.

VA will communicate the new Directive to the field in order for the field to understand the changes from the previous edition, as well as the mandated use of the PDAT. The 0710 Handbook is under development, and an inter-agency workgroup will be established to assist with the Handbook.

OSP Recommendations Open for Over One Year

VAOIG's Semiannual Report to Congress, October 1, 2009–March 31, 2009, lists one VAOIG report with one recommendation more than 1 year old for VA's Office of Operations, Security and Preparedness.

The report, "Audit of the Veterans Health Administration's Domiciliary Safety, Security and Privacy," issued on October 4, 2008, directed the Assistant Secretary for OSP to strengthen controls to ensure physical security surveys are conducted at domiciliaries with controlled substances. On May 28, 2010, OSP provided information on its directive to VAOIG, following the publication of Appendix B, "Physical Security Requirements and Options, VA Directive and Handbook 0730.02." We are awaiting VAOIG's response, although we anticipate that this recommendation and report will be closed.

Conclusion

As a Department, we strive to meet our mission to care and serve our veterans to the greatest possible measures of success and professionalism. However, we value the partnership with VAOIG's work to identify and work with us to ensure that we appropriately and quickly improve. In so doing, we are able to provide the kind of service to our veterans that they deserve and have earned. Thank you again for the opportunity to appear. We are prepared to answer any questions you may have.

POST-HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs
 Washington, DC.
June 10, 2010

The Honorable Eric K. Shinseki
 Secretary
 U.S. Department of Veterans Affairs
 810 Vermont Avenue, NW
 Washington, DC 20420

Dear Mr. Secretary:

In reference to our full Committee hearing entitled "U.S. Department of Veterans Affairs Office of Inspector General's Open Recommendations: Are We Fixing the Problems?" on June 9, 2010, I would appreciate it if you could answer the enclosed hearing questions by the close of business on July 23, 2010.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER
Chairman

MH:ds

Questions for the Record

The Honorable Bob Filner, Chairman
House Committee on Veterans Affairs

U.S. Department of Veterans Affairs Office of Inspector General's
Open Recommendations: Are We Fixing the Problems?

June 9, 2010

Question 1: The Inspector General's Benefits Inspection program identifies approximately 40 (28 percent) out of 145 errors identified by the Veterans Benefits Administration's internal quality assurance program (Sustained Treatment and Rehabilitation Program—STAR) that were not covered by regional office staff. What is your plan to ensure these offices follow the national quality assurance program?

Response: The Compensation & Pension (C&P) Service conducts monthly Systematic Technical Accuracy Reviews (STAR) and other quality reviews to assess national accuracy and consistency of claims processing. When errors are identified regional offices must take corrective action or request reconsideration of the error. If C&P Service withdraws the error, no further action is required.

Regional offices are required to report the corrective actions taken on errors identified through national STAR review during that quarter or indicate that a request for reconsideration has been submitted. Regional office management is required to ensure that all STAR errors and problem quality areas are reviewed and addressed in the regional office's periodic Systematic Analysis of Operations covering the quality of rating, authorization, and fiduciary actions. Additionally, the C&P Program Operations Staff conduct oversight compliance visits of regional offices at least every three years. During the regional office site visit, claims with STAR errors are reviewed and the reported corrective actions validated. Any discrepancies are reported and appropriate followups are conducted with the regional office to validate improvement in deficient areas. Remediation plans are required from stations for all cited action items.

Thus far, in fiscal year 10, 11 percent of STAR error calls have been identified as pending corrective action. Some of the discrepancy in our internal validation reports and the numbers reported by the OIG can be easily explained. VBA's site visit team only identifies errors when corrective action has not been taken. The OIG

identifies errors not only for failure to take corrective action, but also for such procedural discrepancies as leaving the STAR checklist in the claims folder.

VA is strengthening the STAR process. C&P Service will provide the Associate Deputy Under Secretary for Field Operations, through the Associate Deputy Under Secretary for Policy and Program Management with a quarterly report of uncorrected error calls for which reconsideration has not been requested. The report will identify those error calls that are uncorrected for more than 60 days.

Question 2: What are the primary reasons for the delays in implementing the recommendation for the Office of Inspector General's Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements?

Response: The primary reason for the delay in implementing the recommendation for the Office of Inspector General's Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreement was the underestimation of the time required to draft a clinic sharing curriculum and develop the curriculum into a formal training class.

As the formal training class will not be available for attendance until the second quarter of fiscal year 2011, VHA's Chief Procurement and Logistics Office is taking interim measures to correct the weaknesses identified in the report. The measures include establishing standardized written procedures for monitoring and ensuring proper payment of noncompetitive clinical sharing contracts and the creation of a mandated interim training initiative for all contracting officers and contracting officer technical representatives. The training will be completed by August 31, 2010.

Question 3: The OIG talked about the two reports on reusable medical equipment and indicated that at the August 2009 followup review, 129 facilities were compliant with respect to SOPs and 128 had appropriate documentation of demonstrated competence. Yet in March 2010, the IG issued a report (Healthcare Inspection Patient Safety Issues VA Caribbean Healthcare System San Juan, Puerto Rico Report Number 09-03055-103, 3/16/2010) about reusable medical equipment problems at three sites in Puerto Rico. How can this happen?

Response: Office of Inspector General (OIG) published a report on June, 16, 2009, "Use and Reprocessing of Flexible Fiberoptic Endoscopes at VA Medical Facilities." During the inspections related to this report, OIG found that several VHA medical facilities had deviated from recommended procedures in the reprocessing of endoscopes. On September 17, 2009, OIG issued the report, "Followup Colonoscopy Reprocessing at VA Medical Facilities." OIG indicated that this report provided results from August 2009 inspections of all facilities not previously inspected in relation to the June 2009 report and a followup for facilities previously found to be not compliant with Directive 2009-004, Use and Reprocessing of Reusable Medical Equipment in Veterans Health Administration Facilities. The September 2009 report specified that the August 2009 inspections were limited to colonoscopy reprocessing. This report found that among the 129 facilities inspected in August, all 129 of those inspected were compliant with respect to the OIG's review about standard operating procedures while 128 had adequate documentation of demonstrated competence for reprocessing staff. The VA Caribbean Healthcare System in San Juan, Puerto Rico, was one of the 129 facilities visited by the OIG on August 5, 2009, for the followup review, and the OIG did not indicate any concerns in the scope of their review.

According to the reports, the scope of the March 2010 report, "Patient Safety Issues, VA Caribbean Healthcare System, San Juan, Puerto Rico," differed from the OIG's 2009 review of colonoscopy reprocessing. The March 2010 report involving Puerto Rico was a result of an OIG Hotline call that prompted a visit on August 25-28, 2009, to the VA Caribbean Healthcare System. This report did not specifically address colonoscopy reprocessing that was addressed in the June 2009, and September 2009 reports. The report addressed several issues such as training of staff, equipment concerns, and processes that the facility had identified previously and were already working to correct prior to the August 2009 site visit as follows:

- July 2009: The Veterans Integrated Service Network (VISN) 8 Reusable Medical Equipment (RME) Committee conducted a site visit/review and made recommendations to further enhance the San Juan RME program.
- July 2009: The VA Caribbean Healthcare System aligned the RME Committee under the leadership of the Associate Director for Patient Care Services and changed its membership. Committee Members underwent a comprehensive orientation on the purpose and expectation of the RME Committee.

- July/August 2009: Staff involved in the cleaning and reprocessing of RME underwent retraining and the recertification of competencies. RME orientations were held with Service Chiefs outlining their responsibilities. Leadership conducted inspections at RME pre-cleaning and reprocessing sites.

Recently, during the week of June 7, 2010, the VA Caribbean Healthcare System completed their tri-annual unannounced Joint Commission survey. The Joint Commission conducted a focused review on reusable medical equipment during this survey and had no findings.

Question 4: If the Office of Inspector General made recommendations to fix the Fiduciary Program in a 2006 audit, why did they find similar problems in a 2010 audit? It would seem that veterans who need fiduciaries to manage their funds are among the most vulnerable of veterans.

Response: VA agrees that beneficiaries who need fiduciaries to manage their funds are among the most vulnerable veterans. VA is committed to strengthening the program and safeguarding the welfare of veterans and survivors with fiduciaries.

Although VA concurred in the findings of the report, the Acting Under Secretary for Benefits comments indicated that we continued to have serious concerns about the quality of the report.

VA has made significant progress since 2006. The current report identified four recommendations as similar dealing with documenting receipts, staffing, training and the fiduciary IT system FBS. Here is an update on each recommendation and the actions taken.

- Documentation of receipts: Conducted a training conference for Legal Instruments Examiners from all regional offices, providing in-depth training in areas including account audits, estate administration, misuse identification, and surety bonds;
- Completed a total revision, reorganization, and update of the Legal Instruments Program Guide; and
- Released Fast Letter 07–12, *Quarterly Review of Selected Fiduciary Accounting Work Products* to further monitor fiduciaries that are required to submit accountings; and verified and updated all estate values in the Fiduciary Beneficiary System, and required annual updates in the future.

The IG's most recent report expressed their view that more can be done. VA concurred in the finding and strengthened policy guidance in Fast Letters dealing with fund usage; misuse allegation review, investigation and determination; collection of Social Security numbers and taxpayer identification numbers; and onsite reviews. Policy guidance was also updated to require a Legal Instruments Examiner to obtain receipts for any item, regardless of the amount or its inclusion in the fund Usage Agreement, if documentation is determined necessary.

C&P Service further strengthened the program by deploying improved oversight of allegations on the misuse of beneficiary funds. Effective fiscal year 2010, C&P Service Fiduciary Staff is required to complete an annual *Systematic Analysis of Operations* of the misuse process. This analysis will identify the following: areas in which regional offices are following prescribed policies and procedures; areas in which current VBA policies and procedures may be enhanced; and any weaknesses in the fiduciary program as it relates to misuse. In addition, the C&P Service Fiduciary Site Survey Protocol was amended to include a review of all documentation pertaining to any misuse issues addressed.

The IG's second finding was that a fiduciary program staffing model was needed to assure that the Department identifies the needed resources to conduct the program. An analysis of current staffing and workload has been completed and a proposed staffing model has been developed to be used as a guide developed and are currently under review in VBA.

With respect to training, the third area of "similar" findings, the IG focused on their preference for centralized training for Legal Instrument Examiners.

C&P Service deployed a comprehensive training program for all fiduciary activity personnel nationwide. This is a week-long training program to provide clear and consistent training that is delivered by C&P Fiduciary Staff. Additionally, a National Fiduciary Managers Training Conference was conducted in June 2010. As noted in our response to the report, VBA conducts monthly training calls with the fiduciary staff around the country. We believe these calls are effective training tools and we are providing appropriate guidance. The true measure of training is the outcome not the format. We will continue to conduct training of our staff to improve effectiveness.

The fourth area of similar findings relates to the current FBS system. VBA convened a workgroup to evaluate the current electronic fiduciary case management system and to provide recommendations for either enhancements or a replacement system. The workgroup presented its findings and recommendations in June 2010. Based on those findings we have concluded that the current system should be replaced. A Request for Information (RFI) has been prepared and it is planned for release by September 30, 2010. That RFI seeks industry recommendations on how best to design the replacement system to meet the needs of the fiduciary program. Input from that RFI will inform a solicitation for development of the program.

Question 5: Regarding the two administrative investigations reports that were released in August 2009 (while it has only been 10 months) at this rate of 3 recommendations closed out of 45, we don't think you will close all recommendations out within a year. What is the delay and why have you not acted on the egregious behavior of several senior officials?

Response: The VA Office of Information & Technology (OI&T) has initiated corrective action on all recommendations and completed corrective actions on a number of recommendations detailed in the two administrative investigation reports. OI&T has conferred with the Office of Human Resources and Administration and the General Counsel on the recommendations, and made various determinations based on the advice given to each of the claims.

In regards to Investigation Report No. 09-1123-195, "Administrative Investigation—Misuse of Position, Abuse of Authority, and Prohibited Personnel Practices Office of Information & Technology Washington, DC" the former Deputy Assistant Secretary for Information Protection and Risk Management, a Senior Executive and the primary subject of the report, was removed from the Department of Veterans Affairs. Additionally, appropriate administrative actions ranging from admonishment to suspension were taken against various management officials for engaging in prohibited personnel practices. In fact, 8 of the 11 recommendations presented in this report are now closed. OI&T continues to update OIG and is working toward completing the tasks that are necessary to close the remaining recommendations.

In regards to Investigation Report No. 09-1123-0196, "Administrative Investigation—Nepotism, Abuse of Authority, Misuse of Position, Improper Hiring, and Improperly Administered Awards, OI&T, Washington, DC" the former Director, OI&T Human Resources Operations, a primary subject of the investigation, was removed from his supervisory position and demoted to a position that does not require any direct or indirect human resources responsibility. Several of the OIG recommendations included collecting funds from employees whose college tuition was funded by the VA. More specifically, six nonsupervisory employees were identified as having received funds improperly expended to pay for their academic degree. The Office of the General Counsel (OGC) is currently conducting a review of this issue and will soon provide OI&T with a legal opinion regarding the employees' liability. OI&T will forward this information to OIG for final resolution. In the meantime, OI&T issued new guidelines clarifying the approval of government funds for college tuition.

Also, Investigation Report No. 09-1123-0196 identified 10 individuals that were erroneously appointed and/or appointed at a rate above the minimum. OI&T has established a procedure for requesting above minimum rate for new appointees, and continues to confer with the Office of Human Resources & Administration so that the appointment status of all OI&T employees is in accordance with the law.

The Assistant Secretary for OI&T has implemented a new policy regarding the authorization of awards and bonuses over \$2,000, and any award amount where the employee's prior cumulative awards exceed \$5,000 in any fiscal year. The new policy requires that any award recommendation over \$2,000 must be reviewed by the OI&T Office of Human Capital Management—this includes all types of awards, i.e. monetary awards, honor awards, and nonmonetary awards.

OI&T continues to update OIG and is working toward completing the tasks that are necessary to close all remaining recommendations.

Question 6: Why will it take 2 years to complete the standardization of coronary stents and why has the Veterans Health Administrations only started surveying facilities about the aortic valves and thoracic grafts when this recommendation was made in September of 2007?

Response: In 2007, the VA National Director of Surgery determined that there was no need to pursue a national contract for aortic valves and thoracic grafts based upon an independent assessment of relevant surgical volumes for aortic valve and thoracic aortic graft procedures. In November 2008, a new National Director of Surgery was appointed and in July, 2009 an internal review identified that a formal

response to the 2007 OIG recommendations had not been submitted. The National Director of Surgery initiated a survey of the field, and two Integrated Product Teams (IPT) were established in October 2009. The teams reviewed survey data, information from the VA Surgical Quality Improvement Program, and prosthetics data. The findings of the IPT reviews are summarized below:

- With regard to aortic valve implant devices, the IPT determined that a national contract and Blanket Purchase Agreement (BPA) was not recommended. The basis for this decision considered the complexity of the clinical decisions resulting in vendor choice, the variety and availability requirements of implant types (mechanical, bioprosthetic, etc) in relationship to the complexity of the disease being treated, the relatively low number of devices implanted by the VHA, and the established safety of the devices currently utilized.
- With regard to thoracic aorta grafts, the IPT did not recommend either a national contract or BPA. The basis for this decision was the overall low number of thoracic aortic grafts being implanted by the VHA, the complexity of the disease process requiring a choice of available and emerging vendor products, and the established safety of the devices currently utilized.

The recommendations of the Aortic Valve IPT and the Thoracic Aortic Graft IPT were submitted to and accepted by the National Director of Surgery. The National Director of Surgery submitted a declarative statement, consistent with the findings of the IPTs, to the OIG for review and consideration for closing the recommendation.

