OVERSIGHT EFFORTS OF THE U.S. DEPARTMENT OF VETERANS AFFAIRS (VA) INSPECTOR GENERAL: ISSUES, PROBLEMS AND BEST PRACTICES AT THE VA

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

FEBRUARY 15, 2007

Serial No. 110–4

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE
34–306 WASHINGTON : 2007

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

February 15, 2007

OVERSIGHT EFFORTS OF THE U.S. DEPARTMENT OF VETERANS AFFAIRS (VA) INSPECTOR GENERAL: ISSUES, PROBLEMS AND BEST PRACTICES AT THE VA

THURSDAY, FEBRUARY 15, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 3 p.m., in Room 334, Cannon House Office Building, Hon. Harry E. Mitchell [Chairman of the Subcommittee] presiding.

Present: Representatives Mitchell, Walz, Rodriguez, Brown-Waite.

OPENING STATEMENT OF CHAIRMAN MITCHELL

Mr. MITCHELL. Good afternoon and welcome to the Oversight and Investigations Subcommittee for the Veterans' Affairs Committee. This is the meeting of February 15, 2007.

And I would like to begin by welcoming our new Members. And, actually, you are probably not a new Member, are you? I am the new Member, so I guess I welcome—and, Tim, welcome.

First, let me just give a little—and I also want to welcome—forgive me if I make some mistakes here. I was talking earlier about how I needed to know what the protocol here was. And this looks like a very friendly group, so please bear with me.

This is our very first Oversight Subcommittee hearing of the 110th Congress. And today, the VA Inspector General will provide an assessment of issues, problems, and best practices at the VA.

We will also look for avenues in which the Subcommittee can help the Inspector General do a better job. Thus far, it looks like his team is doing a great job with the resources that are allocated.

This Subcommittee has a long history of working with the VA Inspector General. They are the first stop, the first call, so to speak, where our Subcommittee needs a firsthand assessment from a field location regarding operations at the VA's central office.

I have asked the Inspector General to be accompanied by his staff of experts in audit, contracting, healthcare, and investigations. I am interested in their views and as honest brokers as to how the VA as a very large Federal organization is doing.

This topic and this hearing are our place to start our oversight assessment of the VA. The IG has significant knowledge and recent hands-on experience in matters that impact the VA.

I would stress that we do not only want to hear about the VA and what it is doing wrong. We want to hear about what the VA is doing right. We want to hear about the best practices of the VA, and we want to do what we can to see that those practices grow and multiply.

The best situation is when the VA is proactive and identifies and solves problems before they become real problems. We all strive to be proactive, but all too often we end up just being reactive. Out of necessity, we may do both on this Subcommittee, but we will strive to be proactive as often as practicable.

I will now ask my colleague and Ranking Republican Member, Ms. Ginny Brown-Waite, if she has opening comments. I look forward to working with her during the next 2 years, and I recognize Ms. Brown-Waite for opening remarks.

[The prepared statement of Mr. Mitchell appears on pg. 22.]

OPENING STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. Thank you very much, Mr. Chairman, and welcome to the Committee.

This is a Committee that, historically has worked in a very bipartisan manner, because veterans are not Republicans or Democrats. They are veterans needing our assistance.

I appreciate the Chairman yielding me time. This is the first Subcommittee hearing for the Subcommittee on Oversight and Investigations. And, I certainly appreciate the Inspector General coming in and testifying before us regarding the President's proposed budget for fiscal year 2008 as it relates to your office.

The VA's Office of Inspector General is responsible for the audit, investigations, and inspection of all VA programs and operations. Given the recent demand for greater accountability within the business lines at the VA, I am very sure that the workload within your office has increased significantly in the past year.

Therefore, I find the budget before us very disconcerting in that the amount the Administration has requested for the office is 72.6 million, which provides for 445 full-time equivalent employees to support the activities of your office.

During fiscal year 2006, OIG identified over 900 million in monetary benefits for a return of $12 for every dollar expended by your office. The OIG closed 652 investigations; made 712 arrests, just in 1 year; 344 indictments; 214 criminal complaints; and 833 administrative sanctions.

My understanding is that, if the President's numbers prevail, it actually would amount in a reduction of 40 employees from your current staffing level.

I am very concerned that the funding levels the Administration is requesting are not going to be sufficient to continue the very excellent work that has been done by your office. And I look forward to hearing testimony on this matter.

Again, Mr. Chairman, I thank you very much for yielding.

Mr. MITCHELL. Thank you.

[The prepared statement of Ms. Brown-Waite appears on pg. 22.]

Mr. MITCHELL. Mr. Walz.

OPENING STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Thank you, Mr. Chairman, and also congratulations to you. I am proud to work with you on this Committee. I know your reputation far precedes you for your fairness and your work ethic. So thank you.

And I would also like to thank our Ranking Member for such an eloquent statement and a belief that what your office is doing is something we absolutely believe in. You should be commended for the work that you have done on the scarce amount of resources that you have. Protecting those resources for our veterans is a sacred responsibility, and you have taken that obviously to heart and done a very good job with that.

I would concur with our Ranking Member that I am deeply concerned that an area that has proven to be able to return resources to us, an area that has been a good steward of the public trust is an area that we are trying to cut a few corners on. And I want to make sure that this Committee, this Subcommittee, has a clear understanding of what we need to do and how we need to articulate the needs that your office has so that we can get those resources to you to continue with this work.

And I fully believe that it may be one of the most important positions that a lot of people do not know about that is happening in an organization or in our VA system that I think is absolutely critical, especially at this time.

So I thank you. I thank you for taking the time, all of you, for coming today, sharing your expertise with us and hopefully letting us know where we can make your job easier.

So thank you, Mr. Chairman.

Mr. MITCHELL. Thank you.

At this time, we will begin with Mr. Opfer and make your statement.

STATEMENT OF HON. GEORGE J. OPFER, INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JOHN D. DAIGH, ASSISTANT INSPECTOR GENERAL, HEALTH; JAMES O'NEILL, ASSISTANT INSPECTOR GENERAL, INVESTIGATIONS; BELINDA J. FINN, ASSISTANT INSPECTOR GENERAL, AUDIT; MAUREEN REGAN, COUNSELOR TO THE INSPECTOR GENERAL

Mr. OPFER. Thank you, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to appear before you today.

I am accompanied by the senior members of my staff, Maureen Regan, Counselor to the Inspector General; Dr. David Daigh, the Assistant Inspector General for Healthcare Inspections; Belinda Finn, our Assistant Inspector General for Auditing; and Jim O'Neill, the Assistant Inspector General for Investigations.

I would like to recognize that we have had a long history of working with this Committee, and I appreciate the oversight by this Committee and interest in the work that we do. A lot of it, as both of you said, Mr. Chairman and the Ranking Member, is unfortunately we like to do more proactive work, but a lot of times, we are in reactive mode.

Last year, we had to react to issues such as the cranial implant situation, and there was the data loss, with a significant impact on twenty-six and a half million veterans.

I am going to list some of our accomplishments. There is a commercial that says things are priceless. How do I put a value on maintaining the integrity of the quality and safety of care in the VA hospitals? It is invaluable. How do I put a value on maintaining the integrity of the data which is in the hands of VA? It has a significant impact on the twenty-six and a half million veterans and their families and would have an economic impact.

That work was done collectively with the resources that we had within the OIG. We did not just use the investigative staff. We used everyone we had, and I am fortunate to have the staff to do that.

I am in the twilight of my career, starting government service in 1969, and I have only been the Inspector General here for a year. But I have been fortunate my entire career working with and for outstanding people. And nowhere is it more paramount. I have been blessed to be working as the Inspector General in the Department of Veterans Affairs and have these outstanding people and to visit the field offices and to know what they can do and to know what could be done if we had more resources.

But I am not here to ask for resources. I am here to explain what we have done and put some initiatives on the table for consideration of the policymakers to see if this is a role for the IG, if this is something that would be useful for you in making the decisions that affect the veterans of this country.

During the past 6 years, the OIG had a return on investment of $31 for every dollar invested in the OIG operations. We have produced $11.6 billion in monetary benefits and issued 1,200 reports, over 6,600 recommendations. We also completed nearly 15,000 criminal investigations. We have processed over 93,000 hotline contacts and completed over 7,300 reviews of allegations of fraud, waste, abuse, and mismanagement.

OIG oversight is not only a sound fiscal investment. It is investment in good government. To highlight some of the best practices resulting from our work, the VHA has developed a seamless transfer of medical records for returning war veterans. Thousands of unscrupulous individuals who preyed on our veterans by stealing their benefits and abusing fiduciary responsibilities have been prosecuted as a result of our investigations.

We have produced unqualified opinions in VA's financial statements and identified material weaknesses that need correcting. We have also recovered more than $104 million from contractors who overcharged VA.

We have identified systemic problems in major procurements and serious deficiencies in VA's IT security, such as the work I outlined in the theft of the records concerning the twenty-six and a half million veterans.

Despite our accomplishments, I believe that there is much more we could and should be doing if this is the role for the IG in the future.

While we do the most we can with the resources provided, there are many issues that we are not able to review. For example, we

refer over 70 percent of all the hotline cases that we receive back to the Department for review.

As indicated in my written statement, there are several key challenges facing VA that we are not able to review with existing resources. For example, in healthcare, the VA is challenged in its delivery of care to the returning war veterans. Compliance by VA researchers with policies that protect patients and ensure not only sound scientific results is also an area of concern.

VA's research is budgeted for 1.8 billion in fiscal year 2008, which makes the research program commensurate with the IT budget for VA for 2008. A significant amount of funds are being appropriated for VA or are in the process of being reviewed by Congress.

The increasing geriatric veteran population also presents VA with a growing challenge. Veterans 85 years and older enrolled in VA health systems is expected to exceed 675,000 by year 2012. As VA searches for organizational efficiencies, the question of whether the VISN model that they have now in VHA is the best infrastructure to manage the medical care and resources needs to be addressed.

Also drug diversion steals valuable medicine from patients, and makes patients vulnerable to harm from providers impaired by drug use.

I think the timeliness and accuracy of processing claims is a top priority.

Veterans would benefit from OIG work aimed at reviewing VBA's quality assurance program for rating decisions, and assessing the factors contributing to the serious backlog of claims.

The VA's internal controls and accountability of VA funds remain an area of high concern. The OIG, I believe, has an important role to play in overseeing the development of the new integrated financial and logistics system to ensure that VA corrects these material weaknesses.

Systemic deficiencies in VA procurement include lack of communication, insufficient planning, poorly written contracts, inadequate competition, and inadequate contract administration. Independent oversight efforts would benefit VA in determining how best to address these deficiencies.

VA's budget request for fiscal year 2008 estimates a need of 1.9 billion for IT. I believe independent oversight is needed to ensure that system development controls are effective, the requirements are accurately identified and planned, contracts are used to support the projects in the best interest of the government and to achieve the desired results.

As I outlined before, protecting VA data is and will remain a primary focus of ours. It is the society that we live in, the technological age, whether at work or at home.

I would like to emphasize that my office will continue, I believe, to provide a positive return on investment. While I believe the VA OIG has accomplished a great deal in improving VA, we are faced with the challenges I have just discussed, and I need to greatly expand on the oversight to meet these challenges.

In closing, I would like to add that my current resource level is sufficient to meet the mandatory statutory obligations that have

been placed on the IG by Congress, such as reviewing the consolidated financial statement, the FISMA, and other congressional mandates.

However, I believe like most agencies VA is faced with evolving challenges and changing demands. If the OIG is really going to be an agent for positive change, future resource levels need to be commensurate with this challenge.

Thank you for the opportunity to appear here before you today. My staff and I will be glad to answer any questions that the Committee would have for us.

[The prepared statement of Mr. Opfer appears on pg. 23.]

Mr. MITCHELL. Thank you very much, Mr. Opfer.

Let me just ask a couple of quick questions. One, you mentioned how you uncovered some of the contractors who had overcharged and overbilled and so on.

When you find those kind of people, what happens to them? Do they get put back on a list because there is a lack of competition? Are they blackballed? Are they no longer allowed to bid? What happens to them?

Mr. OPFER. Let me have Maureen Regan explain that part of the contractors. There were areas of debarment and other things like that. If it was a criminal nature that we could prove, then that would go to our investigations office. But let Maureen explain.

Ms. REGAN. The agency has the authority to debar them from future contracts. Whether or not it goes through the debarment process depends on a number of factors.

One of them may be how old the conduct was. They also have the opportunity to enter into similar to a corporate integrity agreement. There has been a number of cases we have worked on that affect other agencies and they may have the responsibility to do a debarment or a corporate integrity agreement.

In criminal cases, they do get referred for debarment to our agency if it is against us.

Mr. MITCHELL. One last question, if you do not mind. In response to what Ms. Brown-Waite spoke of, I think we are all concerned with your staffing level, and you mentioned that. And the great job that you and your staff are doing is just terrific.

And as you know, the ratio of the Inspector Generals to the number of people who work in a particular department—for example, my understanding is that the Department of Veteran Affairs is the second largest department in the Federal Government and, yet, you have the lowest number of employees in relation to the parent agency.

And seeing the great success you have had with the people that you have working for you, don't you think it would be great for all of us and certainly good business practices if we raised that ratio?

Thinking of HUD, for example, and the Department of Education, both of them have full-time equivalents of Inspector Generals of 33 times greater than the VA has.

And I think the ratio was something like .2 percent. So it is very, very low. So we are really getting a bang for our buck. But maybe we can get better if you had more staff.

Mr. OPFER. Mr. Chairman, you are correct. If you look at the IG's Office in relationship to the 26 statutory IGs at the Cabinet agen-

cies, if you go by the ratio of FTEs in comparison to the IG's Office with the parent agency, we would be 26. We would be last.

If we look at the ratio of budget authority in comparison to the OIG's budget with the parent agency, we would rank 20th out of 26. So we are last in the ratio of FTE to FTE with the parent agency and third from the bottom of the budget authority.

From my own experience prior to coming to VA as the Inspector General, I served as the Deputy Inspector General in the Department of Labor, and it was a great organization and I enjoyed working there.

The comparison I am trying to make is that agency was of 17,000 employees, and the IG's Office in DoL is about the same size as mine, and, actually, in fiscal year 2008, they would be larger than the VA OIG and that is for an agency of 17,000 employees.

Mr. MITCHELL. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. I thank the Chairman.

I think I threw the Chairman off a little bit when I told him we may be related because I have a granddaughter by the name of Mitchell. My daughter is a Mitchell. And so we are going to check those family trees.

You all do such a great job in the Inspector General's Office, and I mean that sincerely. And, you know, I can be a very, very harsh critic. But the work that you do, we need to be, if anything, plussing up those numbers because of the fact of the dollars saved.

But would you help us to understand the real impact if you lose 40 FTEs? What current services or audits would be affected, and tell me the effect that it would have on the Fugitive Felon program?

Mr. OPFER. Yes, Congresswoman. Let me give a bit of an answer and then I will rely on the program managers to respond specifically, the Office of Investigations to respond to your Fugitive Felon question. And David Daigh will respond to the healthcare initiatives that would be affected, and Belinda Finn will talk about the audit program.

But overall, in a quick summary, in Healthcare, the OIG inspectors would not review the quality of care and patient safety issues at the outpatient clinics. The inspectors would have to cancel most of the planned work on VA research and the identification of best practices and PTSD treatment.

Probably an inspection of the VA pharmacy and medical device programs would have to be delayed or put off completely. We would have to cancel an initiative to expand audit oversight in the VA information systems that would address the material weaknesses that we find in our financial statements and vulnerabilities.

We would have to cancel three national audits. One would be in looking at the accountability controls over some sensitive IT equipment, an audit of VA DoD electronic data, and an audit of VHA's internal controls of financial activities.

I would rather have Jim explain the Fugitive Felon program and if we have time, I would have the program officers elaborate more into the healthcare initiative and the audit initiative.

Jim.

Mr. O'NEILL. Yes. This would be one program that probably would not be impacted directly. We have automated a lot of this program. It has been very successful and I would love to tell you about it if you are interested in the number of veterans and beneficiaries who have been identified in the program, and the number of arrests.

In terms of the process, the data is retrieved from a variety of sources, NCIC, 13 different states, the U.S. Marshals, and it is matched electronically against VA records. We have automated the notification as much as possible to the warrant holders in terms of addresses that we may or may not have for them.

Typically we get involved personally in these investigations in a couple ways. One is when we learn that a veteran who has a warrant is going to appear at a medical center for an appointment and if we are proximate to that location, we may get involved because the burden of that is only a couple of hours, because we always involve local police to represent the warrant holder, and the arrest is actually made by them, and our agents are instructed to provide cover for the arrest, but not to necessarily effect it.

Then we do it on occasion when the warrant is for a heinous crime and there is serious violence and particularly when the local department asks for assistance, we do our best to assist them. We believe that this helps us when we need their help.

Ms. BROWN-WAITE. Could you just give us an idea of the number of felons that have been identified through this process?

Mr. O'NEILL. Yes. Actually, I looked it up. As of September 30th, we had identified 26,763 VA beneficiaries who were identified as having an active felony warrant. Once we identify them, of course, the information is passed on to the warrant holders.

We also pass on the information to comply with the law to VBA who would cease monetary benefits after due process and to VHA to let them know they do not have to provide anything but emergency medical care.

Then both VHA and VBA identify the amount that has been spent, and we provide them the data to do this, from the time the individual was a fugitive felon. There is a start date on that statute. I forget it now. But if it falls within that statute, we identify that date so that they can initiate recovery because the law allows VA to recover the money.

Ms. BROWN-WAITE. I know my time has expired, but one quick question——

Mr. MITCHELL. Sure.

Ms. BROWN-WAITE [continuing]. Mr. Chairman, if you will indulge me. How many felons have you found actually as employees of the VA? And I hate to ask that question, but while we are talking about felons, we might as well get it all out here.

Mr. O'NEILL. Well, I cannot answer how many felons are in VA, but we have identified 154 fugitive felons. We are not doing background checks. We are doing wanted person checks in NCIC and in all the databases we have access to.

So we did identify 154 employees. Ninety-six have been arrested. The remainder were not arrested for a variety of reasons. The warrant holder does not want to pay for extradition, so the employee is encouraged to go satisfy the warrant, clear up the problem, or

occasionally we will find out that actually it was a misdemeanor. It was reported improperly to NCIC or whatever. So that would account for the remainder.

Ms. BROWN-WAITE. Thank you.

Thank you, sir, for indulging me.

Mr. MITCHELL. Thank you.

Mr. Rodriguez.

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

And let me just continue to follow up. I am curious. You said you had 26,000 felons. And how do I say this? What percentage of that has to do with drug related?

Mr. O'NEILL. Well, sir, I would——

Mr. RODRIGUEZ. You do not know?

Mr. O'NEILL. I would not hazard a guess because we have not quantified that. However, I can tell you that a lot of the warrants are for probation and parole violations which, in essence, is a felony, but we do not necessarily always know the predicate offense.

Mr. RODRIGUEZ. You do not know the reason. Okay. Because I know that in prison, we have about 80 percent are due to drug related, and a large number of our veterans, especially Vietnam veterans—I do not want to stereotype—but a lot of them, you know, were, I know, engaged in drugs. And I kind of have a——

Mr. O'NEILL. Well, I can tell you this, sir, that we have arrested, I recall, someone on the Tennessee ten most wanted list. We have had murderers, sexual predators, child sexual rapists. We have a lot of violent predators that we caused to be arrested.

I probably did not say this, but we have confirmed with the law enforcement agencies who are the warrant holders that 1,294 fugitive felons have been arrested based upon the information we provided them. Now, we expect that number is much higher because it is a self-reporting mechanism where they tell us that our data helped them arrest. So we actually think it is higher.

Mr. RODRIGUEZ. Twelve hundred over what, a year or——

Mr. O'NEILL. Oh, no. This would be from the beginning of the program, 1,294.

Mr. RODRIGUEZ. Okay. Which is how long?

Mr. O'NEILL. I would say it was about—I did not bring the beginning date, but it was about 2002 or 2003.

Mr. RODRIGUEZ. Okay. So it has been 4 years, about 1,200 people. So the other 26,000 were others? It was not any of your doing?

Mr. O'NEILL. Pardon me, sir?

Mr. RODRIGUEZ. You said 1,200 were as a result of your work. And so I gather the other 20 something thousand was not?

Mr. O'NEILL. Well, we do not know what happened to the remainder, whether they were arrested, whether they were arrested before we even forwarded the information that we had, or whether they were arrested based upon our information. But the departments have not told us.

Mr. RODRIGUEZ. Thank you.

I was going to ask regarding the audit if that is okay. On the audit, and I have not seen it and I apologize, you know, and I do not even know if we have it before us, but on the audit report that you have, I know I get a lot of complaints about vacancies that have not been filled. Is that reflective on the audit in terms of——

Mr. OPFER. I am not sure, Congressman, I understand which particular audit you are referring to.

Mr. RODRIGUEZ. I gather you do an audit of the VA?

Mr. OPFER. We do a series of audits, some of them in the program offices and various things.

Mr. RODRIGUEZ. Staffing, you know.

Mr. OPFER. Dr. Daigh did one on staffing.

Mr. RODRIGUEZ. Okay. Because I keep getting reports of the number of vacancies that are carried, I guess for the purposes of the budget, but a live person is not there.

Dr. DAIGH. Sir, I am not aware that we publish vacancies not filled. But if you are talking about management of human capital, we are very interested in that. For instance, we have aggressively advocated that VHA develop standards so that they know how many doctors and nurses they should employ, and I believe that one of the initiatives that audit has under proposal here would be to look at human capital and see how VISNs are staffed and see what the staffing relationships are throughout VA.

So I cannot directly answer your question in terms of human capital management, we are very interested in that.

Mr. RODRIGUEZ. Okay. How do you assess whether what is being said is actually occurring?

Dr. DAIGH. With respect to?

Mr. RODRIGUEZ. Staffing.

Dr. DAIGH. Yes, sir.

Mr. RODRIGUEZ. I was a school board member, and one of the ways they packed the budget was on staffing. They said we are going to have 150 teachers when in reality, they only had 125 or whatever. And they used that other money for something else. I am sorry. I do not know how bluntly I could put it.

Dr. DAIGH. Yes, sir. We believe that manpower costs are a significant driver for the cost of delivering healthcare, among other things, and we believe that VHA needs to develop standards for how many specialists and nurses they would like to hire.

VA has made tremendous progress in determining how many primary care providers they should have by determining a panel size so that they would have one family practice or internal medicine physician per 1,200 patients or a number that is reasonable. But they have made much less progress in determining subspecialty provider standards.

In our reports, we have pushed VHA to produce those standards. And we believe that with respect to radiologists, they are nearing production of a standard for radiologists and that they have done a great amount of work to develop standards for other specialties.

Mr. RODRIGUEZ. So I gather we have some of that data already available, and how much work is being done with the number of staff that they have now?

Dr. DAIGH. We are currently not doing a great deal of work on seeing whether the numbers are appropriate because we are trying to get VHA to agree on what the appropriate ratio between patients and staffing should be so that we could agree on how many people they should employ.

Mr. RODRIGUEZ. Okay. But I gather you do not see that as an area of difficulty or a problem?

Dr. DAIGH. We do see that as an area of difficulty and both with respect to administration of VISNs and with respect to the number of nurses and physicians that they need to employ. We think it is imperative that these staffing standards be developed and adhered to.

Mr. RODRIGUEZ. So who checks on them if you are not doing it? Is the GAO the ones who check on that for hospital standards or stuff like that, for existing standards now that exist out there for accreditation of hospitals and clinics?

Dr. DAIGH. My group goes to each of the 150, thereabout, major medical facilities on a 3-year schedule. And we devote most of our energies to assuring that processes are in place to ensure that veterans get quality healthcare, that peer review is ongoing, that other fundamental administrative processes occur so that if an error occurs in the hospital, the hospital will react appropriately to that.

Mr. RODRIGUEZ. But are there not some set standards already for hospitals that exist out there, and are we close to any of those standards? There has got to be some degree of accreditation in certain hospitals already, national standards? Do we go by those at all?

Dr. DAIGH. JCAHO accredits hospitals, and that would be an organization different than ours. And we apply some JCAHO standards to the work we do. The standards that we normally try to apply are VA's policies that they have agreed to and then there are standards for healthcare outcomes that have been promulgated by entities outside of the VA.

Mr. RODRIGUEZ. How do we compare, I guess if we are going to look at our hospitals for the VA, how do we compare our hospitals in comparison to other hospitals that exist in the country?

Dr. DAIGH. Well, one example that we have published that is important is our efforts to look at specific outcomes. The VA has held as a standard that they would screen for colon cancer 72 percent of the patients enrolled to their facilities. We checked that standard.

What we did was we looked at how many patients were actually diagnosed with colon cancer, looked at the medical records, and went backward and determined that, yes, they did screen 72 percent of the patients or actually better than that. In our review, they screened 90 percent of the patients.

The problem was the time to make a diagnosis of colon cancer was way too long, in the order of months. We reported that data both by facility during our CAP reports and we rolled that data up and reported to VHA and the stakeholders in the summary report.

And VHA is now making significant strides to decrease the time between screening for colon cancer and then making a diagnosis of colon cancer. So we have tried to take existing standards and explore VHA's compliance with those standards.

Mr. RODRIGUEZ. Okay.

Mr. MITCHELL. Thank you, Mr. Rodriguez.

Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you, Mr. Chairman.

I have a report, the semiannual report to Congress that was done September 2006. And in it, it lists reports that have been unimplemented for over a year.

Some of these, having been on this Committee, this is my fifth year on the Committee, and, Mr. Rodriguez, you have been on the Committee, too, I am sure some of these will sound familiar to you, things such as the audit of the part-time physician time and attendance, only this shows nine out of seventeen recommendations have been implemented.

An issue real close to me is the issue at the VA Medical Center in Bay Pines. Not all of the recommendations have been implemented. This relates to the CoreFLS System. When you make these recommendations, and they are not implemented, can we cost that out? In other words, when they do not implement these, I know Congress stays on them, which is one of the reasons why we ask for this report. But have you ever been able to quantify when they do not implement them?

Mr. OPFER. Congresswoman, you are right. The "IG Act" requires us to list the recommendations not implemented within a year in our semiannual reports and the last report, I think we listed 22 reports with, I believe, 77 recommendations that were more than a year old. I think one recommendation was over 4 years old and eleven were over three.

The consequence, I believe, of not implementing these OIG recommendations in a timely manner can be significant. I think you have a problem then in your projected cost savings, what could have been achieved during that period when they are not implementing the recommendations. Inefficiencies still continue to go unresolved. Poor services to the veterans can be perpetuated.

To address this a little bit more robustly in our office, because, as you know, we only can issue the recommendations, I am looking at our own followup procedure. My goal is not to accept any response from the Department as far as our recommendations if the implementation plan is over a year. When they respond to our recommendations, if the implementation plan will be taking over a year, we are going to be pushing back very strongly to make sure there is justification why it would take over a year.

Also, I think we want to start doing a quarterly followup within the IG Office of looking at the recommendations, where the agency is in achieving the recommendations. I think we need to be a little more aggressive too.

If we feel one of the program offices, no matter what level that it is, if we really have a sincere belief that they are deliberately not implementing our recommendation or stalling, then I believe I need to elevate that to the Deputy Secretary and the Secretary.

Also, we just met, my staff met with one of our program offices. For example, if it is an audit recommendation or a healthcare recommendation, that would be the two primary ones, that they will become more involved in reviewing what the Department says they are implementing to make sure we are doing some verification that it has truly been implemented.

But we have to do this with the existing resources, both ratcheting up to the Deputy Secretary level and possibly the Secretary level, and also having the program officers that know the issues being more engaged with the Department in looking at what they are doing to implement those recommendations.

Ms. BROWN-WAITE. And certainly, if you have your staff cut you will never be able to do it, absolutely never be able to follow up on these.

But I think it is incumbent on the Committee Members here also to take a look at these reports and let the Secretary and Under Secretary know that these are serious—I do not want to call them flaws—but they are serious problems that need to be remedied.

Mr. OPFER. I agree. My experience in the IG community has been since 1994, serving as an Inspector General to different agencies. And I have always found that when Congress weighs in, the Committees with the agencies, the IG reports are taken much more seriously.

Mr. MITCHELL. Thank you. I have one question.

The IG has been very critical of VA's compliance with the "Federal Information Security Management Act." And it has reported on FISMA's weakness and vulnerability since 2001.

In May of 2006, the VA eventually reported a loss of information of our veterans that had the potential to compromise millions of veterans' identities. And in 2007, at Birmingham there was another incident involving lost data.

Two questions on this. First, how does the VA react to your recommendations and what other areas of concerns besides FISMA and information security has the IG made recommendations that are not being followed?

Mr. OPFER. Certainly. And I will give part of this answer on the FISMA to my AIG for audit.

But in the area of IT security, I think that they are trying to address the issues, but you had a culture established for years. And we have some leadership problems, not at the main VA, but leadership and accountability and responsibility has to be put down at the hospital level, all the facilities. They have to take ownership. There has to be responsibility.

If you have sensitive data, you need to be responsible for how you control that data. They are implementing policies and procedures. But, again, for instance, you would need independent oversight.

But issuing policies and procedures does not necessarily get to the root of the problem. You have to go out and verify whether they are being fully implemented, are they being complied, and if not, are you taking appropriate action against the people. It is a cultural change that we need to do in VA.

As far as the FISMA, I would like Belinda to expand on that answer a little bit.

Ms. FINN. We are currently finalizing our 2006 report on FISMA. In that report, we did a followup on earlier issues and also reported some new problems that the Department needed to address.

They have been responding very positively to our findings in that they have issued, as Mr. Opfer said, policies and procedures. The problem is ensuring compliance of the policies and procedures. It is not automatic as we have seen from recent events. A policy on encrypting a hard drive does not necessarily mean that all the hard drives are encrypted.

We have a number of recommendations to the Department dealing with access controls and system controls. Most of that report

is not published in the public domain, so we probably need to talk separately.

Other areas that we are looking at, actually right now, we are focusing most of our IT efforts on our work related to the financial statement audit and the FISMA. So we really do not have a lot of other results that we can talk about.

We would certainly like to do more audit work looking at actual compliance. We would like to look at controls over removable media. We would like to evaluate all the implementing instructions and how they have been complied with.

Mr. MITCHELL. Thank you.

It sounds to me, in both the questions that Ms. Brown-Waite asked and I asked, it is one thing to offer some suggestions and procedures, but it is another thing to be able to follow up. And that seems to be the crux of all of this.

Let me just ask hypothetically. Would you be able to absorb 200 FTEs in 2008 and if you could, how long would it take for them to be productive?

Mr. OPFER. If we received an increase of that size, I think we could absorb 200 FTEs. What we would try to do is an aggressive recruitment at the journey-level both from the auditors and investigators and healthcare inspectors so you can bring them in with very little training in our programs and start being productive.

Conceptually, we have the initiatives, as I outlined in my statement, where we would use those people. Recruiting should not be a hard issue.

About two years ago in our Office of Investigation, just for two 1811 positions in our Washington office, we had over 50 experienced agents from the FBI, Secret Service, and other OIGs apply for those positions. These are highly-qualified individuals. When we put out an announcement for entry-level positions, they had over a thousand responses.

The mission of VA is something that people like, paying back, helping the veterans who deserve the help. And it is not me. I am the new guy in town. The Office of Inspector General in VA has an outstanding reputation in the IG community and has received a number of awards from the President's Council on Integrity and Efficiency for investigations, healthcare inspections, and audits. This is prior to my watch, so I am not tooting my horn.

In healthcare, Dr. Daigh has a unique responsibility. I am the only IG's Office that has a healthcare inspection unit that has an actual medical professional staff. We have done a great job at being proactive, looking at things. Dr. Daigh has brought in extremely talented people.

I do not think that we would have a hard time recruiting the people. I think almost as they walk in the door, we will get increased monetary returns. Certainly they would at least pay for themselves and certainly in the out years, the second year, I think you would see tremendous increases that they would be able to produce for us.

Mr. MITCHELL. Thank you.

I am going to ask Mr. Rodriguez if he has a question, but at the same time, I hope you will excuse me. I have got to go.

And I turn it over to you, and thank you very much.

Mr. RODRIGUEZ [presiding]. Thank you.

Let me ask you. I think in your report, you had talked about some of the areas where you felt you were lacking or you could do a little bit better. And one of them was looking at mental health; is that correct?

Dr. DAIGH. Yes, sir. If I could comment a minute. I think the returning war veterans, that mental health issues are among the highest priority issues that they face. My primary mission, as I stated, is to ensure the veterans get quality healthcare. And most of my resources are consumed in trying to do that for the 150 something hospitals that VA has.

Veteran mental health issues, in order to address it in a way that I think will bring satisfactory results, I think, requires us to take a more in-depth look at the care actually provided at the sites where healthcare should be provided.

So what I propose that we should do is to look at outcomes of patients who were treated at individual facilities, sit down and talk about the outcomes for those patients with the physicians at those facilities, report our findings as to whether the care was appropriate or not in our cap reports, and then roll up additional data that we uncover as we look at systematic issues in the mental health spectrum across the system and national reports to give data that would be helpful in addressing national policies.

I would also point out that there are 800 CBOCs roughly and 200 vet centers, each of which has a mission in providing mental health activities and care for veterans away from veterans' medical centers.

Mr. RODRIGUEZ. I have been getting reports of the needs of some of the family members. And I do not know. Do we have to do something for the family members to get service now or are they entitled to services?

I am not aware. That is why I am asking, because I was hearing about the young people that are—in fact, there were, I think, possible suicides on the part of family members of veterans.

Dr. DAIGH. Yes, sir. That is a complex issue. We recently published a report on traumatic brain-injured veterans who fought in Iraq or Afghanistan. And in that report, we highlighted the fact that medical care after discharge from the VA and more importantly supportive care after veterans are discharged from the VA, if you live distant from a major medical center can be problematic. We are continuing to follow up on that issue.

The specific issue that you address, I think, relates to the different status of different folks who leave DoD. For instance, a Reservist might be in a different status than a National Guard Member who might be in a different status from an active duty who all might leave under different circumstances.

We are currently exploring this issue in a current study looking at the benefits that are available to individuals depending on their status when they leave DoD. So I think that is a very complex question to answer in terms of what an individual is entitled to.

A simple example might be with respect to healthcare is that some individuals might leave with TRICARE healthcare benefits. Some individuals might leave with VA healthcare benefits. Some individuals might leave with neither. Some might leave with both.

So that complexity exists all across the benefit spectrum for individuals who are veterans.

Mr. RODRIGUEZ. In your report, you also talk about the material weaknesses that need correcting in the area of procurement. And you mention also since 2001, they have recommended more than two billion in potential cost savings by contracting officers negotiating fair or reasonable prices.

Let me ask you, especially because I know we highlighted the negotiations with the pharmaceutical companies on prescription drug coverage, but there was also a report that came out by the organization "Families USA" where—and I am curious to know if the pharmaceutical companies, because I know that that report indicated that they upped the prices prior to us moving on the Medicare piece of legislation 2 years ago, and whether there has been any major changes in that area or whether the negotiations on the part of the VA have been, you know, somewhat positive or, you know, how those costs have changed. Have you looked at that at all?

Ms. REGAN. We have a group called the Office of Contract Review and they do the pre-award audits for all the pharmaceutical contracts and the Med-Surge contracts awarded by the National Acquisition Center. So these are going to be your Federal supply schedule contracts.

Part of that, in answer to your question, is going to be it depends on when they had their contract awarded. If it is a covered drug, which is, I think, more of what you are talking about, the "Veterans Healthcare Act" had a ceiling price for drugs that are on the Federal supply schedule that VA, Department of Defense, Coast Guard, and Public Health Service can buy from.

If their contract has been awarded, they can only go up a certain percentage every year depending on the CPIU. If it is a new contract, they can renegotiate the price.

I do not think I have seen what I would call a significant increase across the board in pricing. A lot of the pricing depends on competition. And so you may see it go down, but we have not seen where the prices have gone up significantly in order to verify the statement that you heard.

Mr. RODRIGUEZ. Thank you.

Make sure we get some additional questions right in. Okay? Does the VA have adequate legal contracting oversight for its portfolio of contracts? Excuse me. Ms. Regan.

Ms. REGAN. I think at the field facilities, they could probably use more support in contracting. A lot of times, they do a lot of scarce medical specialist contracts, contracts for specialists, for physicians. And they get into negotiations where the university is represented by counsel, but there is no counsel—there is not a sufficient number of attorneys to help the VA in the same negotiations to work day to day with them. So with the number of contracts that are out in the field, they could use more contract attorneys working directly with them.

Mr. RODRIGUEZ. So we do not have them at the present time then?

Ms. REGAN. No. There is not a sufficient amount of attorneys to do that work. It is very specialized.

Mr. RODRIGUEZ. Okay. Thank you.

And let me just as we are talking about—I was in the San Antonio community, and we had moved on a clinic there. And I was told that our staff there was pretty good at that aspect of it in terms of looking at that—but that that was not necessarily the case in the main office.

So I was wondering from a perspective of the agency, does it rely mainly on the local hospitals out there or the local states to follow through or, you know, is there some lack of expertise in the agency that needs to be beefed up in certain areas?

I know we just mentioned legal, but are there other areas that, you know, in terms of either, housing and other types of contracts that need to be looked at or——

Ms. REGAN. Are you talking about just on the contracting side?

Mr. RODRIGUEZ. Yes, the contracting side and also—because I know that on clinics now, we are not purchasing facilities. We are basically contracting out and moving in. That is my understanding, or am I wrong?

Ms. REGAN. I am not sure if I can answer that question. I have not seen enough of that.

Mr. RODRIGUEZ. Okay. So I gather, because I was told that the agency still did not have the expertise in some of those specific areas.

Are there areas where we really need to beef up on the expertise of the agency for procurement and those kind of things and contracting?

Mr. OPFER. I think we have issued a number of reports on procurement and have been very critical of the whole procurement process. And that is one of the initiatives that we have. I think if we had additional resources, we certainly would want to go into that. That is a big ticket item for the agency.

And I think within the last couple of months, we have issued at least three or four reports that are very critical of the procurement processes within the agency, and it is not in one area.

Mr. RODRIGUEZ. Have you found them to follow through on that or what is lacking there from your perspective?

Ms. REGAN. I think at this point, we have issued a number of reports on major contracts that were issued, particularly for IT services in which there were a number of problems.

What we are in the process of doing now is to take the work over the last couple years and kind of look for the trends that were in there, and we plan on issuing a report that looks at the overall problems and where we found problems consistently throughout these contracts. And those would be large contracts awarded at the central office level.

We have put out reports in the past about buying practices at facilities in 2001, resulted in a Procurement Reform Task Force, and they have a buying hierarchy now to leverage our buying power at the facility level.

We have not been able to go out and—we have not had the resources to go out and look at how compliant, whether or not it is being complied with and how it has affected spending.

With the healthcare resource for physicians, we wrapped all that work up last year. I guess it was in 2005. They put out a new di-

rective and made people more accountable to do better contracting. They actually have steps in there they are supposed to use, including looking at their resources and what resources do I actually need.

And, again, that is another issue that audit would like to go out and look at, to look at the implementation of that policy and how it has affected healthcare and contracting.

Mr. RODRIGUEZ. Let me yield to my colleague.

Ms. BROWN-WAITE. I was just going to ask if you would be kind enough to yield, Mr. Chairman.

I have a constituent waiting for me up in my office, and I am going to have to leave. But one question along the lines that the Chairman was asking.

Tell me about the Unisys contract, that they were paid $20 million so that you could get out of the contract with no deliverables. Is that accurate?

Ms. REGAN. We looked at the Unisys contract at the time where it had been determined, I think by both parties, that it was not working and they needed to end the relationship. And the issue we were asked to look at was what was the best way for the VA to get out of it or what was in the best interest.

Did they have a right to terminate for cause because Unisys did not deliver the product during the deadlines that were set in the contract or was it in the government's best interest to buy the product that had been developed thus far and that had not been accepted by the VA for payment?

We determined at that time there was grounds to terminate for cause under the commercial item provisions in the Federal acquisition regs. But VA felt very strongly that the project was moving along, that they had several of the deliverables, or I think they called them iterations, but they were deliverables that were almost complete that they wanted to buy and not have to start over again.

The settlement that was recommended was to pay approximately $8.5 million, which was the percentage of work done, and then the rest of the money was supposed to be for travel if Unisys submitted appropriate documentation to support the travel.

They settled for $9.5 and bought the product. And then I understand some of the travel has been paid, but I have not seen any documentation on it.

We did check the product. We had one of our experts, and he said it was a good product and was moving along. We looked at all the program records. At the time, we thought that we were going to complete the product. I think there have been $16.7 million that was paid before this point in time and we accepted deliverables. So it was only another $12 million to settle it.

Ms. BROWN-WAITE. So $16.7 million. That does not include the $12 million?

Ms. REGAN. Right. It is about $30 million all together. Sixteen point seven million dollars had been paid over time for deliverables that had been accepted during various parts of the development of the program.

Ms. BROWN-WAITE. And the project, I am told, does not work. Is this another CoreFLS System?

Ms. REGAN. We understood that the project is not complete and that at the time we made our recommendation, which was in September, that the agency was going to hire a contractor to complete it with the work that had been turned over or purchased from Unisys. At the time we issued our report, a decision had been made that it was not going to be completed because of funding issues.

Ms. BROWN-WAITE. I would like to have some followup on that issue, not here. My time has expired. I do have a constituent waiting. But I would like to followup with you on that. And Mr. Wu will be in touch with you.

Ms. REGAN. Okay. Thank you.

Ms. BROWN-WAITE. Thank you.

Mr. RODRIGUEZ. You talked in your presentation about needing some additional resources commensurate on the changes and the challenges in your packet. Also information management mentioned the need for additional oversight that was needed and especially on information technology and information security and that you still had not done some of the audits. That is because they are being done now or because you need additional resources in order to pull that off?

Ms. FINN. We actually had to cancel two planned audits in the information technology area, so we are not going to be able to do those.

Mr. RODRIGUEZ. And the reasons why?

Ms. FINN. Because we did not have enough resources.

Mr. RODRIGUEZ. Okay. And what kind of resources do you need in order to pull off, you know—for example, those audits were for what? Was it comprehensive in nature or just some site assessments?

Ms. FINN. No. They were specific topics and how VA was handling specific—one of them was information exchange with the Department of Defense.

Mr. RODRIGUEZ. That is critical.

Ms. FINN. Yes. These are critical areas.

Mr. RODRIGUEZ. Do we have a system now because I know I have had people come to me, and one of them was—I guess I'll mention him—Dr. Weiss, who keeps talking to me for the last 2 years that he has got this data where we can follow through on people because we had talked about a technology that we could follow through as they left the military and we could grasp that data and have that information and so that that would not be duplication.

Have we kind of come together with that or are we still working on that?

Dr. DAIGH. Sir, I cannot give you a comprehensive answer, but I will say that in a report we did at Tampa on the death of a Marine a couple of years ago, maybe a year and a half ago, we found the transfer of medical records between DoD and VA at that facility was a significant problem.

We followed up that inspection by revisiting in an unannounced fashion about a year later, and we found that they had made significant progress in providing records from DoD to the VA.

We also found that the larger problem was probably in getting records from civilian sites where the transfer between the DoD site,

which has an electronic record, and the VA had improved, but from the civilian side, it was not so good.

On the computerized patient record that we have on our desk, we can see, when we click on patients, we can see that one can get access to DoD data. It is not always there and it does not right now cover everyone. But we have seen progress in this area over time.

Mr. RODRIGUEZ. But what do we need to do legislatively that might—because I thought we had already worked on that for a few years to try to streamline that process so when a soldier left into the veteran status that instead of redoing everything, that we could just follow through and maybe get some of that data. Is that occurring or is there something that we can still do legislatively to make that happen?

Dr. DAIGH. Sir, I am not an expert really in electronic medical records. I have seen where there is—it has been an ongoing effort, and I am as frustrated as from your question I take you are that there is not a seamless movement of records between the systems.

Mr. RODRIGUEZ. But it is apparent that you do not have enough resources to do those audits anyway. Is that correct?

Dr. DAIGH. That would be correct, sir.

Ms. FINN. That is correct right now.

Mr. RODRIGUEZ. Okay. And so you are asking for what, additional——

Mr. OPFER. We really were not asking for specific numbers. We put out initiatives that we thought should be considered.

Mr. RODRIGUEZ. Considered as you do the assessments?

Mr. OPFER. Right. And I think on the medical records, that probably would be a good question that VHA could probably give you a status of where they are in dealing with DoD. I think Dr. Kussman would be the right one to give you a response for the agency. I know that they have had discussions with DoD. I, quite frankly, do not know what level or where they are on that project.

Mr. RODRIGUEZ. You also mentioned a need to—well, I think was it the procurement aspect of it and then the IT aspect of it? Any other areas that you feel that there might be some gaps upon looking and reviewing?

Dr. DAIGH. Yes, sir. I think there is one area that would benefit from improved oversight and that would be VHA's research program, which is currently about $1.6 billion between appropriated moneys from the VA, NIH, and then non-appropriated moneys.

There are about 2,500 FTE involved in the VHA research community. There are about 85 nonprofits. There are about 150 some odd medical centers, about 85 nonprofits who exist to hold moneys for research efforts by VA physicians, many of whom hold appointments at affiliated medical centers.

Mr. RODRIGUEZ. How many nonprofits?

Dr. DAIGH. There are about 92, I believe, authorized, about 85 active. And that data is—I can update it exactly, but it is in the current budget.

Mr. RODRIGUEZ. And who looks at those nonprofits?

Dr. DAIGH. Sir, the Board of Directors for the nonprofits is in large measure comprised of individuals who work at the VA. So the Director and the ACOS for research and others are, by large measure.

Mr. RODRIGUEZ. Do you have the authority to oversee those nonprofits, I guess?

Dr. DAIGH. We do.

Mr. RODRIGUEZ. Okay. Have you looked at any of those?

Dr. DAIGH. Yes, sir. Well, the healthcare inspections have published two reports recently. We have other ongoing work that will be published soon. And I believe that there are issues with respect to human protections, conflict of interest, management of moneys, animal protections, and radiation safety.

Many of the research efforts require the use of radioactive materials, some of which is at very low level, but nevertheless requires compliance with rules and regulations. And I believe from the work, we have done that, whereas in the healthcare side of VHA, I think that physicians and providers are used to making the right decision about providing healthcare and they understand what the risks are, and they are careful in a way that we all have come to expect.

And from what I have seen from the body of the work this year on the research side, I think the researchers are too aggressively trying to get their research accomplished and too quick to sidestep some of the policies that are in place. At the senior level management, one would much prefer that they took the time to do things exactly correctly and delay the work if that is required and not sidestep appropriate policy.

Mr. RODRIGUEZ. And I agree with you. I think that there is a lot, and I think we are seeing that now, a lot more research coming out that is basically funded by the same people that might be impacted by the results.

I would hope that we would have an opportunity to look at that a little closer, especially within our system, and hopefully we will not have it, because I know we have that in the private sector a lot. And that is an area of serious concern. I know because that impacts directly in terms of certain types of approaches or medications or, diagnoses or, other things that are utilized.

If there are no other questions, then do any of you have any comments? You have the last word.

Mr. OPFER. No, Congressman. Thank you very much. I appreciate the opportunity to appear here. And I have had the opportunity for about 15 months here of working very closely with the staff and this Committee, and it has been a very productive and open and very candid relationship.

And I do appreciate the interest that the Committee Members and the Committee staff have expressed in the work of the Office of the Inspector General. So on behalf of our staff, I would like to say thank you for your interest in our work.

Mr. RODRIGUEZ. Well, thank you very much.

You did not want to give me a last figure for how much you need? I am an appropriator.

Mr. OPFER. I will take anything you give me.

Mr. RODRIGUEZ. Okay. Thank you, sir. Thank you very much.

Mr. OPFER. All right. Thank you.

[Whereupon, at 4:15 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. Harry E. Mitchell
Chairman, Subcommittee on Oversight and Investigations

I would like to begin today by welcoming our new Members from both sides of the aisle, welcoming our witnesses, and our guests.

This is our first Oversight Subcommittee hearing of the 110th Congress. Today, the VA Inspector General will provide an assessment of issues, problems, and best practices at VA. We may also look for avenues in which this Subcommittee can help the Inspector General to better do his job. Thus far, it looks like his team is doing a great job with the resources allotted.

This Subcommittee has a long history of working with the VA Inspector General. They are the first stop, the first call so-to-speak, when our Subcommittee needs a first-hand assessment from a field location or regarding operations at VA's Central Office.

I have asked the Inspector General to be accompanied by staff experts in audit, contracting, healthcare and investigations. I am interested in their views—as honest brokers—as to how the VA, as a very large Federal organization, is doing.

This topic and this hearing are our place to start our oversight assessment of VA. The IG has significant knowledge and recent hands-on experience in matters that impact VA. I would stress that we do not only want to hear about what VA is doing wrong—we want to hear about what it is doing right—we want to hear about best practices at VA and we want to do what we can to see those best practices grow and multiply.

The best situation is when VA is proactive and identifies and solves potential problems before they become real problems. We all strive to be proactive, but all too often we end up just being reactive.

Of necessity, we may do both on this Subcommittee, but we will strive to be proactive as often as practicable.

I will now ask my colleague and Ranking Republican Member, Ms. Ginny Brown-Waite if she has opening comments. I look forward to working with her during these next 2 years.

I recognize Ms. Brown-Waite for opening remarks.

Prepared Statement of Hon. Ginny Brown-Waite, Ranking Republican Member, Subcommittee on Oversight and Investigations

Thank you, Mr. Chairman, for yielding.

This is the first Subcommittee hearing for the Subcommittee on Oversight and Investigations, and I appreciate the Inspector General coming in to testify before this Subcommittee regarding the President's proposed budget for FY 2008, as it relates to the Office of the Inspector General.

The VA's Office of Inspector General (OIG) is responsible for the audit, investigation, and inspection of all VA programs and operations. Given the recent demand for greater accountability within all the business lines at the VA, I am sure that the workload within the Office of Inspector General has increased significantly in the past year.

Therefore, I find the budget before us very disconcerting, in that the amount the Administration has requested for the Office of the Inspector General is $72.6 million, and allows for 445 Full Time Equivalent Employees (FTEE) to support the activities of the OIG. During FY 2006, OIG identified over $900 million in monetary benefits, for a return of $12 for every dollar expended on OIG oversight.

The OIG closed 652 investigations, made 712 arrests, 344 indictments, 214 criminal complaints, 316 convictions, and 833 administrative sanctions. My under-

standing is that the requested funding level would result in a reduction of 40 FTEE from current staffing levels.

I am concerned that the funding levels the Administration is requesting may not be sufficient to continue the work that is currently being performed by the OIG, and I look forward to hearing Mr. Opfer testify on this matter, as well as others.

Again, thank you, Mr. Chairman, for yielding.

Prepared Statement of Hon. George J. Opfer,
Inspector General, U.S. Department of Veterans Affairs

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to address the Office of Inspector General's (OIG's) oversight efforts in terms of issues, problems, and best practices at the Department of Veterans Affairs (VA). We provide independent oversight that addresses mission-critical activities and programs in healthcare delivery, benefits processing, financial management, procurement practices, and information management. We plan our work in each of these strategic areas, which are aligned with the Department's strategic goals.

Today, I will present to you my observations of OIG's overall impact since 2001, and the challenges we face in providing effective oversight of the second largest Cabinet level Department to ensure it effectively carries out its mission of serving America's veterans. We have accomplished much, but there is much more we can do.

With me today are the Assistant Inspectors General (AIGs) for Investigations, Audit, and Healthcare Inspections; and the Counselor to the Inspector General, who will answer questions about their specific programs. The AIGs conduct criminal and administrative investigations, national audits, healthcare inspections, and other reviews in the five strategic areas. For fiscal year (FY) 2007, the proposed joint resolution provides the OIG funding to support 445 full-time equivalents (FTE) from appropriations. This is a reduction of 40 FTE from the previous year. Our Office of Contract Review performs preaward and postaward reviews under a reimbursable agreement with VA, which funds an additional 25 FTE. These reviews of VA contracts produce significant recoveries to the VA Supply Fund, as well as many improvements in processes and practices in the procurement arena.

RETURN ON INVESTMENT

In the 6-year period FY 2001–2006, OIG delivered a return on investment of $31 for every dollar invested in OIG operations. We produced $11.6 billion in monetary benefits from recommended better use of funds, savings, costs avoidances, recoveries, questioned costs, restitutions, and civil judgments. We issued 1,169 audit and inspection reports with 6,601 recommendations to improve services to veterans and to improve the economy and efficiency of VA programs, operations, and facilities. Almost 90 percent of these recommendations have been implemented by VA to date. OIG also completed almost 15,000 investigative actions resulting in arrests, indictments, convictions, administrative sanctions, and apprehension of fugitives, and processed over 93,000 Hotline contacts, which resulted in completion of over 7,300 reviews of allegations of fraud, waste, abuse, and mismanagement. OIG oversight is not only a sound fiscal investment, it is an investment in good government and public assurance. For example, you cannot put a monetary value on a patient's life saved through better healthcare standards or removing an abusive provider from patient care.

To highlight some best-practice accomplishments resulting from our healthcare inspection work, the Veterans Health Administration (VHA) developed new national policies for colon cancer diagnosis and treatment, management of pressure ulcers, management of surgical items that can be left in the body, and seamless transfer of medical records for returning war veterans transitioning from active duty to VA medical care. Our investigative work has led to the successful prosecution of medical providers who have harmed, and in some cases murdered, patients. We have performed oversight work aimed at developing mandated physician and nursing staffing standards. In the benefits area, our work has led to the successful prosecution of thousands of unscrupulous individuals who preyed on veterans by stealing benefits checks, abusing fiduciary responsibilities, and making false claims.

Audits have identified billions of dollars in better use of funds through improved practices. In financial management, we have produced unqualified opinions of VA financial statements for many years while identifying material weaknesses that need correcting. In procurement, preaward reviews since 2001 have recommended

more than $2 billion in potential cost savings by contracting officers negotiating fair and reasonable prices. Postaward reviews of Federal Supply Schedule contracts resulted in more than $104 million in hard-dollar recoveries that went back to the VA Supply Fund. Audit reviews have identified systemic information technology (IT) system development deficiencies in major procurements, such as CoreFLS. Our mandated Federal Information Security Management Act audits have identified serious deficiencies in VA's IT security. We have also successfully completed investigative work on major IT data loss cases, such as the loss and recovery of the data on 26.5 million veterans and active duty personnel.

Despite our significant accomplishments, I believe we have only scratched the surface on what we can contribute to helping improve VA programs and activities. For example, while we do the most we can with the resources provided, there are many issues we are unable to review within existing resource levels. For example, we cannot investigate or review all Hotline complaints. In fact, we must refer 70 percent of all Hotline cases to the Department for review. I believe VA would benefit from an independent and objective review of these cases by the OIG because the OIG-performed substantiation rate is 20 percent higher than the Department. Furthermore, business is growing—our Hotline contacts are up 16 percent over this point last year. We also decline more criminal investigation cases than we prefer due to our high per capita agent caseload of 16 to 1, which is one of the highest in the OIG community.

We focus our resources on the most important and urgent issues facing VA at the time and will always do so, but this often results in delaying review of other important high priority planned oversight work. I would now like to take this opportunity to discuss some of these high priority issues by strategic area.

HEALTHCARE DELIVERY

OIG work has helped VHA improve the quality of medical care through our focused reviews, healthcare inspections, audits, and investigations. During the past 6 years, the OIG has invested about 40 percent of its resources in overseeing healthcare issues.

Issues that have received little attention in past years but offer significant opportunity for systemic improvement involve services provided to returning war veterans, medical research activities, care of elder veterans, VHA's Veterans Integrated Service Network (VISN) structure, and drug diversion at VA medical centers and mail-out pharmacies.

Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) veterans are receiving care, as are other veterans, in a nationwide system of over 150 medical centers, 800 Community Based Outpatient Clinics, and over 200 Vet Centers. While we believe the quality of medical care in VHA facilities is generally excellent, VA is challenged to deliver mental health services and provide seamless transition of care from active duty to veterans who live in areas distant from VA facilities. Compliance by VA researchers with policies that protect patients and ensure sound scientific results is another area of concern. VA research is budgeted at $1.8 billion in FY 2008, which makes the research program commensurate with the entire VA IT budget. The increasing geriatric veteran population presents VA with constantly changing challenges to care for elders at VA facilities, contract nursing homes, and at home. Veterans 85 years and older enrolled in VA healthcare are expected to exceed 675,000 by 2012.

As VA searches for organizational efficiencies, the question of whether the VISN model offers VHA the best infrastructure to manage its healthcare resources and provide access to quality care needs to be addressed. The size of operations and the highly decentralized nature of these activities add to the complexity of this issue.

Drug diversion steals valuable medicines from patients who need them and makes patients vulnerable to harm from providers impaired by drug use. VA has over 1,300 sites nationwide where drugs are provided or stored with unique circumstances that can be exploited by those seeking to steal drugs. VA would benefit from independent OIG systematic facility reviews—immediately focusing on information contained in automated dispensing systems—to identify and investigate instances of drug diversion.

BENEFITS PROCESSING

The Veterans Benefits Administration (VBA) faces rising workload levels, in terms of both absolute numbers and complexity, and is anticipating receiving 800,000 claims in both FYs 2007 and 2008 from returning war veterans and veterans of earlier periods. The pending inventory of disability claims alone rose to almost 400,000 by the end of FY 2006.

The timeliness and accuracy of processing these claims remain a top priority for VBA. For example, VBA reports progress in reducing its error rate for compensation core rating work to 12 percent, but this rate remains unacceptably high in a program of over $40 billion. I believe VBA and veterans would benefit from OIG oversight work aimed at reviewing VBA's quality assurance program for rating decisions and an assessment of other contributing causes of timeliness problems to address the serious backlog of claims in VBA.

FINANCIAL MANAGEMENT

Although VA has received a series of unqualified audit opinions, it has three material weaknesses that impact its ability to safeguard and account for VA financial operations. The lack of an integrated financial management system increases the risk of materially misstating financial information and requires significant labor-intensive manual processes to prepare auditable reports for the Department. Other material weaknesses are deficiencies in financial operations oversight and continuing problems with IT security controls.

The annual audit of VA's Consolidated Financial Statement does not address other important financial activities or provide a detailed review of individual accounts. We do not know, for example, if other high risk areas, such as VA financial, statistical, budget, and performance measures and reports, including the validity of automated VA data, are accurate and reliable. Additionally, VA's internal controls over, and accountability for, the use of VA funds remain an area of high concern.

I believe the OIG has an important role to play in overseeing the development process of new integrated financial and logistics systems to ensure that they systematically address the needs of VA and correct material weaknesses.

PROCUREMENT PRACTICES

VA spends over $6 billion annually in supplies, services, construction, and equipment. In the past 6 years, we have issued a number of reports involving individual failed procurements that resulted in large dollar losses to VA and serious delays in significant projects needed to improve VA infrastructure. Systemic deficiencies include the lack of effective communication, little or no acquisition planning, poorly written contracts, inadequate competition, poor contract administration, and inadequate legal support.

We believe the organizational structure of VA's procurement activities and the lack of oversight and accountability are factors that have significantly contributed to these problems. Because procurement activities are decentralized, it is difficult to conduct an in-depth oversight program on a nationwide basis. There is no central database identifying contracts that have been awarded, individual purchase orders, or the amount of money spent on goods and services.

Effective oversight can improve contracting practices and help avoid losses due to fraud, waste, abuse, and mismanagement. To this end, I believe VA would benefit from national audits conducted by staff who possess the specialized skills, knowledge, and experience in the rapidly changing environment of Federal acquisitions. Efforts are also needed to determine whether VA procurement activities could benefit from the same centralization that VA is implementing in IT.

INFORMATION MANAGEMENT

VA's budget request for FY 2008 estimates a need to spend $1.86 billion for the IT appropriation. At a time when VA is realigning its IT governance and resources, OMB identified dozens of VA systems on its high risk watch lists. VA's automated information systems have not provided management with sufficient information for effective decisionmaking, are not fully integrated, and are difficult to use. The current IT consolidation within VA is a critical first step to establishing an effective IT governance structure, but does not guarantee success. It remains to be seen whether VA's realignment will enhance operational effectiveness, provide standardization, and eliminate duplication in the delivery of information management services.

Independent oversight is needed to ensure system development controls are effective, requirements are accurately identified and planned, and contracts used to support projects protect the Department's interests and achieve optimum results. VA will continue to face challenges in implementing its enterprise architecture, and ensuring that it addresses the entire range of managerial, operational, and technical controls necessary to oversee the IT architecture.

We have not been able to provide comprehensive audit oversight of information security controls over VA systems. VA has identified almost 600 IT systems. To date, we have only been able to review a very small percentage of these systems. I believe VA would benefit from more national audits of information management and governance, IT investments, and information and system security. This will

help VA improve its management practices and security controls over its sensitive information, thereby helping VA institute changes that could prevent further exposure of sensitive data.

The loss of VA data on millions of veterans and active duty military personnel last year highlights the challenges facing the VA in the area of information security. As we briefed your staff, we currently are reviewing the circumstances involving a missing external hard drive containing sensitive data from a VA facility in Birmingham, Alabama. These reviews are complex and labor intensive.

Concern with protecting VA data is and will remain a primary focus for years to come. This is not just a VA concern, but a national issue that reflects the technological age we live and work in. This is an area that will continue to require significant OIG resources and oversight in the future. To this end, I believe VA would benefit from an OIG rapid response capability, using teams consisting of criminal, administrative, and computer forensic investigators who would immediately assess the magnitude of the breach and implement an investigative protocol built upon successful methods used in prior incidents.

CONCLUSION

My office will continue to provide oversight of VA programs through a combination of proactive and reactive audits, healthcare inspections, and criminal and administrative investigations. We will continue to provide positive return on investment not only in terms of monetary impact, but also in management collaboration, good government, and public trust. While I believe the OIG has accomplished a great deal in improving VA, we are faced with the evolving challenges I have set forth above and the need to greatly expand oversight to meet these challenges.

In closing, I would like to add that my current resource level is sufficient to meet my mandatory obligations and respond to high priority issues raised by the Congress and VA. However, I believe VA, like most agencies, is faced with evolving challenges and changing demands. If the OIG is going to be an agent of positive change, future resource levels need to be commensurate with this challenge.

Thank you again for the opportunity to discuss these issues with you today. My staff and I would be pleased to answer any questions.

POST–HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Questions from Hon. Harry E. Mitchell, Chairman, and Hon. Ginny Brown-Waite, Ranking Republican Member, Subcommittee on Oversight and Investigations, to Hon. George J. Opfer, Inspector General, U.S. Department of Veterans Affairs

U.S. Department of Veterans Affairs
Inspector General
Washington, DC
March 21, 2007

The Honorable Harry Mitchell, Chairman
The Honorable Ginny Brown-Waite
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman and Congresswoman Brown-Waite:

Thank you for the opportunity to appear before the Subcommittee on February 15, 2007, to discuss the Oversight Efforts of the VA Office of Inspector General: Issues, Problems and Best Practices at the U.S. Department of Veterans Affairs.

Enclosed are our responses to the followup questions from you and Congresswoman Ginny Brown-Waite. If you need further information on the work of the Office of Inspector General, please do not hesitate to contact me.

Sincerely,

George J. Opfer
Inspector General

For the Inspector General

1. State your view of the Department's management of its Workman's Compensation Program. What do you estimate the cost savings would be with more aggressive case management?

Response: In August 2004, the OIG issued a report on the costs of VA's Workers' Compensation Program (WCP) that found that WCP case management was ineffective and that program fraud existed (*Audit of Department of Veterans Affairs Workers' Compensation Program Costs*, Report No. 02–03056–182). In our FY 2004 report, we estimated $588 million in WCP costs could potentially be avoided for lifetime claimant benefits through improved case management. We also estimated $108 million in WCP compensation costs could potentially be avoided for projected lifetime claimants through improved fraud detection. The Department concurred with the potential cost savings in our report and the need for enhanced WCP management throughout VA.

VA has implemented significant initiatives to address the findings and recommendations presented in our 2004 report. For example, VA formed a Workers' Compensation (WC) Strategic Planning Committee, comprised of representatives from throughout the Department in October 2004, and VA's Strategic Management Council approved the WC strategic plan in February 2005. Programs were developed to promote professional development, case file review, WC education, and quality assurance programs. Action was also taken to develop performance criteria to measure WCP case management effectiveness. While a number of improvement actions involve complex organizational issues, improved program oversight is being achieved in a collaborative manner through the WCP Steering Committee. VA has implemented actions to evaluate the adequacy of compliance with WCP performance criteria and is working with the Department of Labor to contain and reduce program costs.

2. In your estimation, where do you think there are excessive employees in the Department or offices with redundant or duplicative missions?

Response: VA has recently taken steps to consolidate Information Technology (IT) personnel who were decentralized throughout all VA offices. This consolidation presents VA with the opportunity to identify and eliminate redundant positions.

Similar opportunities exist with the current decentralization of procurement throughout VA, which needs to be addressed as part of a larger effort to fix VA's acquisition problems. These problems are outlined in response to Question One addressed to the Counselor to the Inspector General.

3. Have you reviewed patient waiting times—specifically mental health appointments? PTSD?

Response: We have not specifically reviewed mental health appointment waiting times but we have reviewed the broader issue of waiting times (*Audit of VHA's Outpatient Scheduling Procedures*, Report No. 04–02887–169, July 2005). This review addressed the Veterans Health Administration's (VHA) compliance with outpatient scheduling procedures to determine the accuracy of the reported patient waiting times and facility waiting lists.

VHA measures patient waiting times by comparing the desired appointment dates to the actual appointment dates and strives to schedule at least 90 percent of all next available appointments for veterans within 30 days. Only 65 percent of these appointments were scheduled within 30 days of the desired dates based on our analysis. We reported outpatient scheduling procedures need improvement nationwide. As part of this audit, 116 of the 1,104 outpatient appointments examined were mental health appointments. We determined that 11 of the 116 appointments were incorrect—they were either the wrong desired date or the wrong appointment type.

We are conducting a current review of VHA's outpatient waiting times. The scope includes eight specialties, audiology, cardiac, eye care, gastroenterology, mental health, orthopedics, primary care, and urology. We expect to issue a final report in June 2007.

4. You stated that from 2001–2006 the OIG delivered a 31 to 1 return on investment. We understand that last year, the OIG's return on investment was somewhat lower—at a figure closer to 12 to 1. At the same time, you report that you faced a dramatic resource loss in the OIG of some 40 FTE. What impact did the loss of personnel have on the reduced return on investment?

Response: The return on investment of OIG oversight fluctuates from year to year depending on the magnitude of individual audit, investigative, contract review, and healthcare inspection results; however, it has always been a positive ratio over the past 6 years. At the time we reported FY 2006's 12 to 1 return on investment, the 40 Full-Time Equivalents (FTE) reduction had not occurred, so it did not contribute in any way to that figure. We anticipate seeing the FY 2007 reduction in OIG FTE impacting next year's return on investment. Using the average return on investment over the past 6 years of 31 to 1 in terms of a return per planned FTE, we estimate a reduction of 40 FTE would result in a drop of approximately $174 million in monetary impact of OIG operations annually.

5. What would happen to both the net revenues returned to the Department as a result of fines, penalties, cost avoidance and the like, and to the basic return on investment per dollar invested in the OIG, if the number of FTE in the OIG were to grow back to FY 2006 levels? What if the number of FTE at the VA OIG were to increase to the next smallest statutory IG's ratio of FTE to parent organization FTE, and you had a staff of about 750? Would this reap more benefits than it would cost?

Response: Our long-term experience demonstrates a positive return on investment year after year, so we estimate that any increase of the OIG FTE resource level would reap more benefits than the increased FTE would cost. Using the 31 to 1 return on investment that OIG has achieved over the past 6 years, the restoration of 40 FTE would be expected to result in $174 million in return on investment annually.

We estimate a staffing increase of 280 FTE to reach 750 FTE would be expected to result in about $1.2 billion in additional monetary benefits annually for VA.

6. The IG conducts Combined Assessment Program, or "CAP," reviews of VA facilities nationwide. How often does a facility face a review, and are you able to reassess each facility to assure that followup actions are complete whenever findings indicate the need for further action?

Response: On average, we review VA medical centers on a 3 year cycle. Facilities that are deemed to be at the most risk are reviewed in consecutive years. OIG has a followup process for all recommendations including those in CAP reports. This

process involves the facility certifying they have taken corrective action and the OIG agreeing with the certification. On selected critical issues, in addition to the written certification, an onsite inspection may occur.

7. We note in your testimony that IG audits have identified billions of dollars in better use of funds through improved practices, cost avoidances, and other methods. How does the IG establish a baseline and measure the results of its actions to account for this claim?

Response: In our semiannual report to Congress, we include the monetary benefits of recommendations contained in OIG reports issued during the reporting period. The monetary benefits are determined using Government Auditing Standards (GAS) set by the Comptroller General of the United States. By following GAS, the OIG ensures that the monetary benefits reported are reasonable, prudent, and quantified. OIG audit work uses comparative and statistical sampling techniques to ensure the validity of data serving as the basis for identifying and reporting monetary benefits. Statistical techniques allow us to project the results to larger populations. Through the report drafting and comment process, we solicit and consider our audit clients' concerns, assess the viability and appropriateness of using alternative estimates, and work to reach agreement with audit clients to ensure the reliability and reasonableness of the monetary benefits reported.

8. Why has the VA had so much difficulty fielding information technology systems and programs? I refer to HR LINK$, CoreFLS, PFSS, and VETSNET—especially the BDN replacement component of VETSNET. Each of these has either failed or had large cost overruns. What is VA doing wrong?

Response: We found that program offices in these and other procurements for services failed to adequately plan for the procurement, which ultimately led to their demise. In particular, the program offices failed to adequately define their requirements. The second deficiency was poor contract administration by both the program and contracting offices. This includes the failure to monitor performance and take corrective action in a timely manner. We also have identified the use of open-ended contracting vehicles, such as blanket purchase agreements and other indefinite delivery indefinite quantity type contracts, and option year contracts, as contributing to the failures of contracts for services needed to develop IT systems and programs.

9. The VA OIG invested significant time and effort into the May 2006 data loss. You interviewed numerous witnesses and specialists, and produced a report that was refreshing in its candor. Did the IG validate the explanation the VA employee gave for having numerous databases such as mustard gas and project SHAD? Were the VA researcher's activities confined to the research he described? If so, why did he have the SHAD and mustard gas databases?

Response: The OIG validated the explanation the VA employee gave for having each of the numerous databases on his hard drive, most of which were discovered on the recovered external hard drive. He was assisting the Veterans Benefits Administration (VBA) outreach efforts by identifying former military personnel whose names and service numbers, but not Social Security numbers, were contained in what has become known as the "mustard gas" spreadsheet by comparing them with data stored in other database files he possessed. The Project 112/SHAD database was part of the "mustard gas" spreadsheet that was included in the VBA outreach project. Finally, it should be noted that this spreadsheet was not found on the recovered external hard drive.

For the Assistant Inspector General for Healthcare Inspections

1. Last year the IG investigated a situation where nonsterile prosthetic implants were implanted in patients at a VA hospital. This Committee is aware of another situation at VHA where part of an invasive medical device was not correctly sterilized at several medical centers. In each situation, both the instance of an unsafe medical practice and apparent delays of sometimes circuitous routes that the bad information traveled before it came to our full attention are of concern. What is the IG doing to promote safe practices during invasive medical procedures, and do you believe that the notification process is working properly?

Response: Following last year's hearing in patient safety issues before the House Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, we

met with senior VHA officials to discuss supply processing and distribution policy and practice. VHA subsequently initiated a series of actions to address these issues, including the publication in January 2007 of VHA Directive 2007–001, *Ensuring Sterility of Non-biological Implantable Devices*. We also recently completed a national review on operating room safety, *Review of Patient Safety in the Operating Room in Veterans Health Administration Facilities* (Report No. 05–00379–91, February 28, 2007). The OIG will continue to examine patient safety through the environment of care and quality management portions of CAP reviews and through inspections related to complaints received by the VA OIG Hotline. OIG work underway includes an Office of Audit project on the acquisition and management of surgical implants to assess the effectiveness of VHA oversight and we expect to issue a final report in August 2007. The OIG has not specifically evaluated the patient notification process as it relates to invasive medical procedures.

2. What are the pressing quality-of-care issues that affect returning war veterans, and how could the OIG contribute to improvements in their care?

Response: Two important issues are the management of mental health issues to include Post Traumatic Stress Disorder (PTSD) and related conditions, and the availability of quality medical care at sites that are distant from the medical center.

Outcome based reviews of PTSD, affective disorders, and substance abuse disorders, in a sample of veterans recently evaluated at the medical center, would permit OIG to make specific recommendations to improve local care and include information on how individual medical centers respond through our CAP reports.

A review of the policies and outcomes for care provided to returning war veterans at the more than 800 outpatient clinics and 200 Vet Centers would similarly improve veterans' medical care. As highlighted in the OIG report, *Healthcare Inspection Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation* (No. 05–01818–165, July 12, 2006), veterans have significant supportive care requirements upon discharge from inpatient care. OIG inspections would report on VHA's efforts to provide these veterans with required services and medical care with the effect of improving the full scope of care provided to veterans.

Other issues that we are concerned with are the effective use and maintenance of high-technology prosthetic devices, the full lifetime of the veteran's management of orthopedic injuries of returning war veterans with amputations, and VA's ability to provide specialized care to war veterans with serious blast injuries to the head, eyes, and extremities.

3. How would you approach assessment of VHA researchers' compliance with appropriate policies and regulations, and what would you expect to find?

Response: In addition to national reviews of VHA research, the OIG would perform a compliance-based review of the research activities at each facility visited during a CAP inspection. This review would address topics that include compliance with policies that address human research protection, animal welfare, security of research data, and radiation safety. Based on prior work, the OIG would expect to find that the research community may be taking unacceptable risk by sidestepping the strict interpretation of applicable current policy. As a result, some research protocols may not include appropriate human protection measures, that research data may not be properly compartmentalized and secured, and that policies may not be updated to reflect the current national standard.

4. What are the key issues facing VA in providing care for the elderly?

Response: The quality of medical care provided at VHA facilities is generally excellent. However, the provision of supportive care for elders varies across the nation. Included in the issues that the OIG could evaluate are local demands for supportive care such as nursing home and in-home assistance programs; specialty care such as cardiology, neurology, and orthopedic surgery; and VHA's current local progress at meeting these demands through the multiple programs that are currently available. This could be accomplished as national programmatic reviews that are targeted to address issues of concern to the elderly, as well as part of the CAP hospital inspection process.

For the Counselor to the Inspector General

1. What do you see as the major problems impacting VA in the area of procurement?

Response: Our work has identified significant problems at most stages in the procurement process. This includes planning, soliciting and evaluating proposals, and contract administration. The most significant problem influencing all these deficiencies is VA's organizational structure for acquisitions. Procurement activities are so decentralized that VA does not know what was purchased, who it was purchased from, who made or approved the purchase, whether it was a contract or open market purchase, what was paid, or whether it was a fair and reasonable price. A majority of the acquisition workforce does not work for the Office of Acquisition and Materiel Management, but for various entities within VA such as VHA and VBA.

Although the Office of Acquisition and Materiel Management has authority to issue warrants to contracting officers and issue policy, it does not have authority to conduct oversight to ensure that the contracting officers are complying with laws and regulations or acting in the best interest of the Government. As a result, there is little to no VA oversight of procurement activities and no accountability. Oversight is an important internal control. Lack of oversight not only results in acquisitions that are not in the best interest of the Government, it allows for criminal activity to go undetected. This includes bribery, kickbacks, and theft.

With respect to individual procurements, we have found that most failed procurements are the result of poor acquisition planning, poor contract administration, or both. For example, we often find that program offices do not adequately define their needs or the timeframe needed to complete the procurement, identify the type of contract that is best suited to meet the need, how performance will be monitored, or perform the required independent cost estimates needed to budget appropriately. Lack of effective communication between the program and contracting offices during the planning process also contributes to these problems.

We also find deficiencies on the part of the program and contracting offices resulting in poor contract administration. The most significant are the failure to monitor contract performance, take action in a timely manner when the contractor fails to comply with the contract's terms and conditions, and ensure that invoices are supported by the proper documentation before authorizing payment.

2. Are adequate legal counsel staff and contract supervision resources used by VA to oversee its portfolio of contracts? What impact does VA's emphasis on competitive sourcing-type activities have on legal and contracting resources?

Response: Based on our reviews of contracting actions, we have identified a problem with the lack of legal support. There are an insufficient number of attorneys in the Office of General Counsel to provide adequate legal support on a daily basis to the contracting entities located at VA facilities nationwide. In our view, both contracting and program offices would benefit from onsite legal support during all phases of the acquisition process.

We have not performed sufficient work to determine whether the ratio of experienced contracting officers to the number of contracts being managed is an issue either locally or nationwide. However, the results of our audits and reviews of VA contracts have shown a need for better oversight of VA's contracting practices.

We also have not performed sufficient work to determine the impact, if any, that an emphasis on competitive sourcing-type activities has on legal and contracting resources. However, based on our pre- and post-award reviews of contracts awarded by VA medical facilities pursuant to 38 U.S.C. § 8153 to obtain healthcare resources, we have identified a need for greater legal support to ensure that the contracts are legally sound, to provide assistance in negotiations, and to assist contracting officers in making decisions relating to contract administration.

For the Assistant Inspector General for Investigations

1. You mentioned the need for a proactive approach to drug diversion. What additional steps can the OIG take to detect and deter drug diversion at VA facilities?

Response: With additional staff, each field investigator would be assigned ownership of one, but not more than two, VA Medical Centers and Consolidated Mail Outpatient Pharmacies for the purpose of proactively identifying and eliminating drug diversion. This would be accomplished by frequent examination of paper and electronic audit trails associated with the receipt, storage, dispensing, and destruction of pharmaceuticals; onsite assessment of controls and vulnerabilities at each site; close interaction with staff in order to increase awareness of signs of drug diversion and to cultivate sources of information about such activity; and increasing our partnership with VHA management in Headquarters and the field to address this prob-

lem. We would specifically concentrate our efforts first on facilities that have implemented *Pandora*, an automated tool designed to detect drug diversion.

A comprehensive diversion mitigation strategy cannot be limited to just our internal concerns. Diversion schemes may occur at any point along a continuum from receipt of the drugs into the VA system, up to the actual delivery of pharmaceuticals to the veteran. While the individuals who divert drugs may use the drugs themselves, these diverted drugs also have the potential of being illegally sold on the streets of our communities. Therefore, we also proactively seek beneficial partnerships with Federal, state, and local law enforcement whose jurisdictional responsibilities complement our own. With additional criminal investigators we would be better positioned to participate on task forces, thereby enhancing our ability to identify and disrupt potential diversion schemes, and maximize our ability to investigate and arrest offenders.

2. What impact have the major data breaches been on OIG resources? What would you estimate is needed to address future data loss cases?

Response: The major data breaches have consumed significant OIG resources. For example, approximately 3,600 staff hours were devoted in May and June 2006 to the criminal and administrative investigations of the Montgomery County, MD, data theft. The current criminal and administrative investigations on the data loss in Birmingham, Alabama, presently involve 20 employees working full-time and performing significant amounts of travel.

Due to the complex nature of data loss cases, we estimate that we would need additional staff to address future data loss cases. We estimate that we need an additional 30 FTE to address future data loss cases and to assist the Department in addressing network security. This staff would include computer forensics specialists, database analysts, network security specialists, forensic auditors, as well as criminal and administrative investigators. This group would assess network security and critical information assets protection, conduct penetration testing, and investigate network intrusion.

For the Assistant Inspector General for Auditing

1. How can the OIG improve its oversight of VA's procurement and acquisition programs and activities?

Response: While past audit efforts have addressed individual or localized problems such as contract award and administration and supply chain management issues, we would like to expand OIG oversight to address more nationwide issues. With additional resources, we would establish an audit division dedicated to procurement and acquisition programs and activities. This division would be comprised of staff with the specialized skills, knowledge, and experience needed to address the rapidly changing and complex environment of Federal acquisitions. The division would provide for a more systematic, disciplined, strategic, and proactive approach to reviewing VA's procurement and acquisition processes.

For example, more audit work is needed to examine staffing, organization, processes, and procurement actions of VA's current decentralized approach to acquisition. We would expand our oversight of historically problematic areas such as Government Purchase Card Program activities, acquisitions supporting major IT systems and development, and the award and administration of clinical services contracts, along with other major business line acquisitions. We would also increase our oversight at VA's local facilities and major acquisition support centers such as the National Acquisition Center.

2. How can the OIG help VBA address problems with the accuracy and timeliness of claims?

Response: Currently, we are conducting several audits of VBA claims processing activities. These audits include:

- Examining whether VA regional offices process Operation Enduring Freedom/Operation Iraqi Freedom veterans' claims accurately and promptly (final report expected in September 2007).
- Determining if VA's compensation system messages are an effective control for ensuring the accuracy of compensation claim payments (final report expected in September 2007).
- Determining if VA regional offices promptly process nonrating claims such as death pension claims and disability and death dependency claims (final report expected in July 2007).

With additional staff, we could perform national audits to evaluate the impact of various resource and procedural shortcomings and recommend specific actions to fix those issues. These audits would be based on a comprehensive strategy to provide information on all claims processing activities instead of evaluating individual activities.