



Department of Veterans Affairs Office of Inspector General

Interim Report - Patient Care and Administrative Issues at VA Medical Center Bay Pines, Florida

Contents

	Page
Executive Summary	i
Introduction	1
Purpose.....	1
Background.....	1
Scope and Methodology	2
Results and Conclusions	3
Issue 1: Canceled and Delayed Surgeries	3
Issue 2: SPD Deficiencies	6
Issue 3: VA’s Deployment of CoreFLS	9
Issue 4: CoreFLS Security Controls.....	18
Issue 5: CoreFLS Contract Procedures	22
OIG Contacts	25
Report Distribution	26

Executive Summary

Introduction

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) is conducting an evaluation of clinical and administrative management issues at VA Medical Center (VAMC) Bay Pines, Florida. The review was initiated after receiving requests from the Department of Veterans Affairs Secretary and Congressional members and committees to review allegations questioning the adequacy of clinical and administrative activities at the VAMC. We are issuing this interim report to disclose the progress of the review and to be responsive to these requests. A final report will be issued when we have completed our review of all the allegations.

Issues under review include: the reasons for surgery cancellations; cardiac catheterization complication rates; radiology backlogs and waiting times; neurosurgery transfers; unexpected deaths; waiting lists and waiting time for outpatient care; physician and fee physician time, attendance, and payment practices; and Supply Processing and Distribution (SPD) operations. We are reviewing management of the testing of the Core Financial and Logistics System (CoreFLS) at the medical center, and the effect of that testing on fiscal, logistical, and clinical care activities. In addition, we are reviewing allegations questioning the adequacy of workplace communication, working conditions, productivity, and processing prosthetics clothing allowance claims for service connected veterans.

This is a joint review conducted by OIG investigators, auditors, and healthcare inspectors. This interim report provides our findings to date on surgical cancellations, SPD operations, and the deployment of the CoreFLS system.

Results

VAMC managers cancelled surgeries because critical surgical supplies and instruments were not consistently available or properly sterilized by SPD. The reported problem involving the unavailability of medical-surgical supplies was only one of a number of long-standing problems identified in SPD at the medical center that went uncorrected. Other identified deficiencies included improper sterilization procedures, inadequate inventory practices, and poorly trained staff. These and similar deficiencies were reported by the Office of Acquisition & Materiel Management (OA&MM) in January 2001, the OIG Combined Assessment Program (CAP) team in January 2003, and by internal medical center reviews of SPD operations in September 2003 and January 2004.

Our review also showed that, notwithstanding reported obligations of about \$249 million of the approximate \$472 million budgeted for the implementation of CoreFLS, VA CoreFLS project managers still have significant work to do to implement the CoreFLS system at the VAMC Bay Pines test site. VA management needs to aggressively oversee and act on this initiative because

they are paying over \$4 million per month to BearingPoint, an integration contractor, to deploy CoreFLS, and as implementation and testing at other VA locations is delayed, costs will significantly increase.

The following issues warrant management attention:

- Data conversion issues need to be resolved so that employees can rely on the accuracy of the system.
- VA employees need to be more involved in testing procedures to ensure the system is meeting their needs.
- VA employees need to be trained to use the system.
- VA managers need to implement all prior recommendations made by an independent private verification firm and VA review groups to improve system performance, configuration management, quality assurance, cost management, and system functionality.
- Interface issues need to be resolved to permit other VAMC systems to communicate with CoreFLS.
- Information Security, such as segregated duties, access controls, contingency planning, accountability and application change controls needs to be improved to protect assets and information stored in the system.
- CoreFLS contracting processes need to be strengthened.

This is an interim disclosure report, and as such, there are no recommendations. We are providing recommendations to VA management as we proceed with this review, and will include them in the final report.

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Introduction

Purpose

The OIG is conducting an evaluation of clinical and administrative management issues at VA Medical Center (VAMC) Bay Pines, Florida. The review was initiated after receiving requests from the Secretary of Veterans Affairs and Congressional Members to review allegations questioning the adequacy of clinical and administrative activities at the VAMC. We are issuing this interim report to be responsive to these requests.

Background

The Secretary of Veterans Affairs requested that the OIG review operations at the medical center as a result of articles appearing in the St. Petersburg Times in February 2004.¹ The articles reported allegations that patient care and service to veterans was suffering due to a variety of issues relating to poor management practices, in particular, problems associated with testing of a new financial and logistical management system called CoreFLS.

Subsequently, on February 19, 2004, the OIG received a letter from Congressman Steve Buyer, Chairman, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs requesting the OIG review various issues at VAMC Bay Pines. Senator Bob Graham (D-Florida), Ranking Member, Senate Committee on Veterans' Affairs, also sent a letter to the VA Inspector General dated February 20, 2004, "...formally requesting an investigation into the practices at the Bay Pines facility." Senator Graham's letter specifically asked that the OIG review issues relating to "The malfunction of the CoreFLS..." that resulted in "...delays in elective surgeries and major shortages of surgical supplies." Other related matters were also cited for review, including a number of personnel issues. The Senator also expressed the desire to be kept informed of the progress of the review.

The OIG also received a copy of a letter to the Secretary of Veterans Affairs dated February 23, 2004, from Senator Bill Nelson (D-Florida). The letter expressed the Senator's concern for the lives and safety of veterans served by the medical center, his support for the OIG review, and asked that he be kept informed of the progress of the investigation.

On March 10, 2004, the Chief and Director, Surveys and Investigations Staff of the House Committee on Appropriations, informed the Secretary of Veterans Affairs of their plans to investigate the implementation of the CoreFLS system at the request of Chairman C.W. Bill Young (R-Florida). We met with Congressional staff to brief them on our ongoing review of the CoreFLS system and provided the members summaries of our work since October 2003.

¹ St. Petersburg Times article, "Bay Pines Delays All Surgeries Next Week" dated February 14, 2004, and St. Petersburg Times article, "VA Chief Visits to Check Up on Bay Pines" dated February 5, 2004.

VAMC Bay Pines is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at seven community based outpatient clinics located in Clearwater, Naples, Manatee, South St. Petersburg, Sarasota, Port Charlotte, and Avon Park, Florida. In addition, there is a large, multi-service outpatient clinic in Ft. Myers, Florida. The VAMC is part of Veterans Integrated Service Network (VISN) 8 and serves a veteran population of about 322,000 in a primary service area that includes 9 counties in Florida. In FY 2003, medical center surgeons completed 3,604 operative procedures including orthopedic, urologic, vascular, plastic, and thoracic surgeries.

Scope and Methodology

This is a joint review conducted by OIG auditors, healthcare inspectors, and investigators to review the allegations. Issues under review include: the reasons for surgery cancellations; cardiac catheterization complication rates; radiology backlogs and waiting times; neurosurgery transfers; unexpected deaths; waiting lists and waiting times for outpatient care; physician and fee physician time, attendance, and payment practices; and SPD operations.

We are reviewing management of the testing of the CoreFLS system at the medical center, and the effect of that testing on fiscal, logistical, and clinical care activities. In addition, we are reviewing allegations questioning the adequacy of workplace communication, working conditions, productivity, and processing prosthetics clothing allowance claims for service-connected veterans.

This interim report provides our findings to date on allegations relating to surgical cancellations, SPD operations, and the deployment of the CoreFLS system.

We interviewed employees and clinicians, reviewed quality management and administrative records, and reviewed the medical records of select patients. We also reviewed management of the testing of CoreFLS at the medical center, related information security issues, and contracting activities. We have provided interim advisories on various issues to VA management on the CoreFLS deployment dating back to October 2003. Our review of the implementation of CoreFLS is continuing, and we will issue a final report when our work is completed. We may also issue additional interim reports as necessary.

Results and Conclusions

Issue 1: Cancelled and Delayed Surgeries

Summary

VAMC managers did not properly supervise SPD assets, which resulted in the cancellation of 81 surgeries in November of 2003 and February of 2004. In addition, we found serious deficiencies in the process that provides sterilized surgical instruments and equipment to the Operating Room (OR).

Interim Results

VAMC Managers Cancelled Surgeries Because Critical Surgical Supplies and Instruments Were Not Consistently Available Through or Sterilized by SPD

The SPD Service cleans, processes, stores, and distributes sterile and non-sterile supplies, instruments, and medical equipment for clinical use. SPD has significant surgical support responsibility to ensure that all necessary supplies and equipment are sterilized and readily available for operative procedures. SPD inefficiencies and errors at the VAMC have negatively impacted patient care activities.

To prepare for surgeries, OR nursing employees review surgeries scheduled for the next day and complete “pick tickets” that identify items needed for each upcoming surgical case. SPD employees are supposed to stock OR case carts based on the pick ticket requests. In the past year, OR nurses noted an increase in the number of supplies or instruments missing from case carts. The OR Nurse Manager attributed this to the retirements of skilled SPD employees. The OR nurse manager told us that she addressed individual case cart deficiencies directly with the SPD supervisor as they arose. She also told us that, in mid-October 2003, she notified the Nurse Executive of ongoing SPD problems after she could not locate urinals for patients waiting in the OR surgical holding area. The Medical Center Director and Chief of Staff (COS) cancelled 37 elective surgeries scheduled for November 19-21, and November 24 in response to the issues raised by the following cases that occurred between September 26 and November 6, 2003:

- A urologic surgery was cancelled because the laser was not on the surgical case cart.
- An orthopedic surgery was cancelled because the sterile instruments made available for this procedure were past the sterilization expiration date. The patient scheduled for the procedure had been medicated for surgery prior to cancellation.

- An 8:00 A.M. general surgery procedure was delayed because the surgical case cart was not delivered to the OR.
- A general surgery and a vascular surgery case were delayed because the surgical case carts lacked necessary supplies and instruments.
- Two urologic procedures were cancelled because appropriate medical instruments were not available in the medical center.

Managers informed us that they cancelled the 37 elective surgeries in November 2003 to allow the facility an opportunity to “take a pause, regroup, and be sure it is right”. All 37 elective surgeries were rescheduled, and the last rescheduled surgery was completed on January 23, 2004. Urgent and emergent surgical cases were completed as scheduled, and were not affected by the stand-down. According to the COS and OR nurse manager, SPD performance improved for a brief time after the surgery stand-down, only to deteriorate again soon thereafter. The COS, Associate Medical Center Director, Chief of Acquisition and Material Management Service (A&MM), Nurse Executive, and the OR Nurse manager held daily meetings to discuss OR needs and SPD support.

From February 17-20, 2004, the Director and other senior managers cancelled the following surgeries as a result of several incidents the previous week that compromised quality patient care and safety:

- During a urologic procedure, a surgeon wanted to perform a cup biopsy. However, a cup biopsy forceps was missing from the surgical case cart, and SPD was unable to provide a replacement. The surgeon obtained a brush biopsy specimen for diagnosis instead of the cup biopsy he desired.
- A general surgery procedure was cancelled because the disposable suction irrigation tubing was missing from the cart and not available in SPD. The patient was in the surgical holding area when his surgery was cancelled.
- A gastric bypass patient suffered a major post-operative intra-abdominal hemorrhage and was returned to the operating room for emergency surgery. SPD staff informed the OR staff that the VAMC’s only omni bariatric retractor, an instrument desired by the surgeon, had not been sterilized after a morning surgical case and was, therefore, unavailable. SPD employees flash sterilized the retractor, and surgeons were able to control the patient’s bleeding. The patient survived the emergency surgery and is recovering at home. The facility has since purchased a back-up omni bariatric retractor.
- OR nurses identified foreign matter that appeared to be dried blood on instruments that were presented for use to the OR by SPD.

A total of 44 elective surgical procedures were cancelled in February 2004. Five patients’ surgeries were completed within 72 hours of the original scheduled surgery dates. The

remaining 39 elective cases were rescheduled, with some of these cases still to be performed as of the date of this report.

Surgical Service resumed operative procedures on February 23, 2004, with instructions to limit scheduled surgeries to 10 per day, rather than the previous average of 15 surgeries per day. Facility managers realigned SPD under Nursing Service on February 19, 2004, and VISN 8 detailed the Tampa VAMC SPD Chief to the VAMC on March 1, 2004, to evaluate and address supply and sterilization problems in the service.

The OR nurse manager told us that on March 12, 2004, a patient scheduled for a total hip replacement had to have his surgery delayed for over 7 hours because the instrument trays had water on the inside drapes and on the instrument set. The OR nurse manager reported the incident to SPD and the instrument sets were returned for sterile processing. The sterile processing had to be repeated twice because the first time the instrument sets were returned to the OR they were still wet.

The confluence of CoreFLS implementation, SPD staff performance and training deficiencies, and lack of effective leadership has resulted in an organizational culture where clinical staff works around the system to ensure patient care needs are met. The OR nurses double and triple check case carts prior to surgeries; dialysis nurses maintain a mini stockroom with a one week supply of equipment, tubing, and other supplies; and the cardiac catheterization nurse borrows procedure kits from a private hospital.

Clinicians are providing patient care in spite of the SPD problems. Surgical Service nurses usually identify missing or improper supplies or instruments prior to scheduled surgery, and work with SPD to secure the correct items. However, emergency surgeries do not allow nurses the same opportunity to ensure that case carts are complete and accurate. For this reason, we believe that emergency cases, particularly those occurring on the night shift (when there is only one SPD employee in the VAMC), pose risk to quality patient care and safety. We informed the Medical Center Director of our concerns.

Issue 2: SPD Deficiencies

Summary

We found that many of the problems identified in our evaluation were previously identified to VAMC management in reports by the OIG and other VA review teams. Among the most serious of these deficiencies is the inability of VAMC staff to maintain properly stocked emergency carts (crash carts).

Interim Results

VAMC Managers Needs to Correct Known SPD Deficiencies

Reported problems involving the unavailability of medical-surgical supplies were only one of a number of long-standing problems identified in SPD at the VAMC that went uncorrected. Other identified deficiencies included improper sterilization procedures, inadequate inventory practices, and poorly trained staff. These and similar deficiencies were reported by the OA&MM in January 2001, identified by an OIG CAP team in January 2003, and identified a third time by a September 2003 internal VAMC review of SPD operations. Another internal VAMC review of SPD operations in January 2004 showed that these problems continued.

Deficiencies Cited by OA&MM Were Not Corrected. OA&MM cited the following deficiencies in January 2001:

- Sterilization practices needed improvement. Sterile item package contents were not properly identified on labels; expiration dates were not designated on packages destined for the Dental Clinic; and sterilizer charts and printouts were not signed, only initialed.
- Expired medical supplies and corrugated shipping containers were found in the Preparation area, clean/sterile storage area, ward supply closets, and in the Operating Room.
- Expired sterile items were found on shelves in the SPD clean/sterile storage area. These same items were being gas sterilized some of the time, and steam sterilized other times.
- The “Stock Status Report” in the SPD primary inventory point indicated excessive amounts of stock that was inactive while the staff complained about stock outages.
- Required items were not delivered to clinicians.
- The Generic Inventory Package (GIP) was not used properly.
- SPD and warehouse storage areas were not secure.
- Staff was not adequately trained.

The former Chief of A&MM developed a corrective action plan but transferred from the VAMC before the planned actions were completed. The current Chief of A&MM stated that while some actions were taken, not all cited problems were corrected. He cited leadership and supervision

problems in SPD, turnover in key staff, and the lack of a well-trained and motivated workforce as areas that continued to need improvement at the VAMC.

We found the following problems at the VAMC during our evaluation:

- Case carts were missing required items.
- Medical instruments were not properly sterilized.
- Inventory controls needed strengthening.
- SPD staff continued to place multiple orders for stock items while inventory records indicated large quantities on hand.
- Required items were not delivered to clinicians.
- GIP was not used, which led to major problems with conversion to CoreFLS.
- SPD and warehouse storage areas were not secure.
- SPD staff was not adequately trained.

Crash Cart Replenishment Deficiency Reported in OIG CAP Review Was Not Corrected.

The OIG reported in its Bay Pines CAP report, dated July 29, 2003,² that crash carts did not always contain essential supplies and equipment necessary to perform life support procedures. We communicated this finding and the need for corrective action to VAMC management at the conclusion of our site visit on January 12, 2003. Code Blue Quality Service Reports for FY 2002 showed that intravenous tubing, gloves, tape, and suction devices were frequently missing from crash carts. We recommended that the medical center director improve controls over, and accountability for, crash cart replenishment. Managers told us that the SPD supervisor attended Code Blue meetings and addressed crash cart deficiencies as they occurred. We advised managers that this approach was reactive rather than proactive, and had not resolved the problems. VAMC managers did not agree with the finding or recommendation, and told us that they had implemented corrective actions prior to our site visit. They confirmed, however, that they had not documented the corrective actions. Approximately 4 months after our CAP visit, we obtained agreement with the finding. Since our January 2003 CAP review, VAMC reports showed multiple additional incidents in which crash carts were missing essential items. In one case (November 27, 2003), the crash cart did not contain an intubation tray (a prepackaged kit that includes intubation items), intravenous tubing, and an airway mask. The nurse completing a portion of the evaluation form documented her suggestion to improve the code: "Roll some heads in Central Supply (former name of SPD)." During another Code Blue on February 3, 2004, code team members noted that the intubation tray was missing. In this case the patient did not require intubation.

Deficiencies Reported by VAMC Internal Reviews Were Not Corrected. VAMC staff conducted two reviews of SPD operations that showed a continuation of problems previously cited by OA&MM and the OIG. For example:

² Combined Assessment Program Review of the VA Medical Center Bay Pines Florida, Report Number 2003-00700-140, dated July 29, 2003

- An OR/SPD Issue Status Sheet dated September 24, 2003, cited incomplete picking tickets for case carts, instrumentation not available for case carts, unsterilized items, inadequate inventory levels, and a lack of focus by SPD staff.
- During the period January 12-23, 2004, two VAMC staff members (Quality Systems and Nursing Service employees) conducted an evaluation of SPD's surgical case cart process to make recommendations for improvement of patient safety. The team identified multiple problems in SPD related to CoreFLS, leadership, staff focus, process management, and customer focus. The team also noted SPD's "casual approach" to maintaining crash carts.

Management did not ensure that a critical area of the VAMC was able to accomplish its mission, despite multiple clear warning signs. SPD's inability to properly provide supplies and services places patients at risk of receiving substandard medical care.

Issue 3: VA's Development of CoreFLS

Summary

Our review showed that, notwithstanding reported obligations of about \$249 million of the approximate \$472 million budgeted for the implementation of CoreFLS, VA CoreFLS project managers still have significant work to do to implement the CoreFLS system at the VAMC Bay Pines test site. VA management needs to aggressively oversee and act on this initiative because they are paying over \$4 million per month to BearingPoint to bring CoreFLS operational, and as implementation and testing at other VA locations is delayed, costs will significantly increase.

Many of the problems with the CoreFLS project resulted from the manner in which the project is managed. We found that: data conversion needs management attention, employees need sufficient training to use CoreFLS, and management needs to implement prior recommendations to improve the functionality of the CoreFLS system. System test results may not provide assurances that the CoreFLS system will meet VA needs. We also found that CoreFLS needs to interface with other VAMC systems, such as Veterans Health Information Systems and Technology Architecture (VistA) and Personnel Accounting Integrated Data (PAID).

Discussion

VA contracted with BearingPoint who is integrating CoreFLS, which will provide VA facilities an integrated financial and acquisition system. VA's current Financial Management System (FMS) and numerous legacy systems interfacing with it, such as the Integrated Funds Distribution Control Point Activity Accounting and Procurement (IFCAP), are old technology and expensive to maintain. There is limited knowledge sharing between related systems.

We have reported on VA's need for an integrated financial management system as far back as the audit of VA's Fiscal Year (FY) 1991 financial statements. We reported this issue as a long-standing material weakness in our Financial Statement Audit in 2003.³

CoreFLS is an integrated commercial off-the shelf (COTS) software financial and logistics system which, when fully implemented, is intended to be used by every financial and logistics office within VA. The system consists of "Oracle Financials" for accounting, budget, contacting, and purchasing; Maximo⁴ for asset management; and DynaMed⁵ for inventory. DynaMed is currently used at 14 hospitals and 75 extended care facilities in Alberta, Canada.

³ "Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2002 and 2003" Report No. 03-01237-21, Dated November 14, 2003

⁴ Maximo is the software for asset management and maintenance.

Planning for a new system began in 1998. In August 2000, VA selected Oracle Corporation, from among seven vendors to demonstrate its software products in a pilot program. The pilot was completed December 15, 2000. CoreFLS was then tested at VAMC Fayetteville, NC from November 5, 2001, through December 20, 2001. BearingPoint's test results demonstrated that implementing the COTS system with no modifications would not meet VA's financial and logistics requirements. As a result of the test, VA was able to identify gaps in the software, which needed to be corrected using software extensions (extensions are modifications to software code). The extensions facilitated the tailoring of the basic COTS system to meet VA's anticipated requirements.

In May 2002, the VA CoreFLS project management recommended a "focus or model" site approach. The VA CoreFLS Acting Project Director met with key personnel in each of the VA administrations to determine the sites best suited to complete the software configuration. The VA administrations recommended the following sites: Bay Pines Medical Center for Veteran Health Administration (VHA); St. Louis Regional Office for Veterans Benefits Administration (VBA); and Florida National Cemetery (Tampa) for National Cemetery Administration (NCA). Developing extensions required additional funding and additional time as extensions were outside the scope of the original project plan. This was estimated to cost \$115 to \$135 million. The estimated project completion was extended to March 2006.

A meeting of the VA CoreFLS Executive Project Committee members comprised of senior leadership in VACO was held in June 2002. At the meeting, VA CoreFLS project management requested approval for the new "Go Forward Strategy Update," including the new development at VAMC Bay Pines, the mandatory top 10 extensions for development, and commitment for the additional funding. The first project phase titled "Build 1.1" was tested from October 2002 through March 2003.

The Under Secretary of Health and the Assistant Secretary for Management signed a Memorandum of Understanding in December 2002 agreeing to fund CoreFLS and to designate VAMC Bay Pines as a focus site. From May 2003 through July 2003, Integrated Test Cycles (ITCs) of CoreFLS were conducted at VAMC Bay Pines. The purpose of ITCs is to validate the software through the simulation of actual business processes in a controlled environment using predefined test scripts. From August 4, 2003, through September 5, 2003, the second project phase titled "Build 1.2" tests was conducted at VAMC Bay Pines, Florida National Cemetery, VBA St. Louis Regional Office, VA Financial Services Center, VA Austin Automation Center, and VA Central Office. CoreFLS was implemented in "Operational Test Phase 1" on October 6, 2003, in Bay Pines, St. Louis, and the Florida National Cemetery.

The total budgeted costs for CoreFLS is \$472 million. According to the VA Chief Financial Officer, as of February 29, 2004, VA has obligated approximately \$249 million. As of January 2004, BearingPoint charges are about \$4 million per month. As the implementation and testing for other locations is delayed, the costs will increase.

⁵ DynaMed is a registered trademark of and published by Dynamic Medical Information Systems.

As part of our continuing financial audit activities, we began reviewing CoreFLS testing, training, and controls in August 2003. We observed the deployment of CoreFLS at VAMC Bay Pines during our site visits in August, October, and December 2003, and in February 2004. We briefed the VA CoreFLS Project Director and issued memorandum reports in October, November, and December 2003 on our observations and received written responses from the Project Director.

On October 2, 2003,⁶ we reported to the Assistant Secretary for Management and VA CoreFLS Project Director our concerns related to not using parallel processing when several risks had not been mitigated. We reported unmitigated risks associated with incomplete and untested service contingency planning, incomplete comprehensive roll back plan, inadequate training to prepare employees to use CoreFLS, unreliable test procedures and results, and unsubstantiated performance results. The Project Director deployed CoreFLS to VAMC Bay Pines on October 6, 2003, without mitigating the risks.

On November 12, 2003,⁷ we reported to the Assistant Secretary for Management and VA CoreFLS Project Director continued risks associated with the implementation of CoreFLS. Our evaluation revealed unmitigated risks associated with system security, user roles and responsibilities, user support, system performance, data conversion, and system interfacing. The Project Director responded that they would utilize this information for input to future deployment decisions.

At the request of the Assistant Secretary for Management, we conducted a follow-up evaluation to determine if risks had been mitigated. On December 23, 2003,⁸ we reported to him that previously reported risks had not been mitigated. The VA CoreFLS Project Director responded that project-wide risks were being constantly reviewed and mitigation actions were being put in place for all known high-risk areas.⁹

Interim Results

Data Conversion Needs Management Attention

Our review showed that VA CoreFLS project management responsible for converting CoreFLS related data and test procedures did not confirm the accuracy of the applicable fiscal and acquisition legacy information prior to conversion to the CoreFLS system.

The Joint Financial Management Improvement Program (JFMIP) issued a white paper titled "Financial Systems Data Conversion Considerations" dated December 20, 2002, that raises awareness of financial systems data conversion considerations when planning or implementing a

⁶ Evaluation of Transition Risks Associated with CoreFLS Build 1.2, dated October 2, 2003

⁷ Evaluation of Deployment Risks Associated with CoreFLS Build 1.2, dated November 12, 2003

⁸ Follow-up Evaluation of Deployment Risks Associated with CoreFLS Build 1.2, dated December 23, 2003

⁹ OIG Memorandum on Follow-up Evaluation of Deployment Risks Associated with CoreFLS Build 1.2, dated January 12, 2004

new financial management system. A key conversion objective is to ensure that set-up data is correctly established and tested prior to conversion. Adequate testing should be factored into the conversion plan to ensure that required data edit and validation tables and values are complete and accurate and that transactions to be compared against them conform to edit and validation rules and codes. Particular attention needs to be paid to potential problem areas, such as: inventories, physical assets, contracts, accounts receivable, or accounts payable.

We interviewed the VA CoreFLS Project Manager and found that work still needs to be done to implement the CoreFLS conversion. For example, during our visit to VAMC Bay Pines in December 2003, the payment cycle field in the “accounts payable” record was not converted accurately. One vendor sent the medical center a final notice that it was disconnecting water and sewer services for failure to pay a \$160 bill. The bill was paid prior to the discontinuation of service, but this example illustrates the uncertainty of payments for many services, most of which are required to be paid timely in accordance with the Prompt Payment Act.

During our visit in February 2004, fiscal records showed interest paid by the medical center due to late payments on orders totaled about \$9,900 for the first 5 months of FY 2004, as opposed to less than \$600 for the entire year in FY 2003. This is a monthly rate of about \$1,980 for the first 5 months in FY 2004, as opposed to about \$50 per month for FY 2003, which is an increase of over 3,800 percent. Fiscal Service estimated that about \$4,600 of the \$9,900 incurred in FY 2004 was the result of the implementation problems involving CoreFLS. These figures have not been validated by the OIG.

As of March 18, 2004, the medical center’s “Invoice on Hold Report” contained 330 invoices valued at \$772,000 that were on hold for various reasons. Invoice payments are placed on hold by CoreFLS when checks are returned to Treasury, address information in the system is erroneous, there are insufficient funds to pay the obligation, or when there are mismatches between the invoice, receiving report, and/or purchase order amounts. These figures have not been validated by the OIG.

As of February 25, 2004, the medical center reported 137 accounts payable totaling approximately \$470,000 that were 30 days or more delinquent. The delinquent accounts ranged from 32 days to 351 days. An additional 137 accounts totaling about \$1.2 million were also past due but were delinquent for less than 30 days. These numbers have not been validated by the OIG.

The Chief, Fiscal Service indicated that invoice statistics are distorted due to systems issues involving Prompt Payment Act calculations and the inability to back date receipts to prior periods. The Chief estimated that about 22 percent of the station’s invoices have been paid on time since the deployment of CoreFLS.

When we visited VAMC Bay Pines in October 2003 and again in December 2003 we found that DynaMed was not fully operational at the medical center because inventories were inaccurate, vendor files were corrupt, and resource objectives and reorder points were erroneous. We found that employees could not electronically transfer all medical supplies between the warehouse and

SPD. We learned this occurred because staff did not validate the compatibility of the units of measure between the GIP system and CoreFLS during the conversion phase of the project. To illustrate, in one line item, the GIP used a “case” as a unit of measure and CoreFLS used a “box” as a unit of measure. The incompatible units of measure between the two systems rendered many line item inventories inaccurate.

In addition, we found that medical center staff worked with incomplete data in vendor records. As an example, some vendor files were missing account numbers and contact numbers. Account numbers are the customer identification numbers used by vendors to identify customer information and are necessary to order supplies. The account numbers allow the vendors to retrieve customer names, addresses, phone numbers, and purchasing histories. Consequently, fiscal and acquisition staffs do not have a complete listing of vendors that they are doing business with on a daily basis.

GIP was used to populate the DynaMed module with historical data about the medical center’s usage of medical-surgical supplies and current quantities on-hand. While SPD had installed GIP, they did not use it or any other automated inventory management system prior to CoreFLS to manage inventories, but instead relied on manual inventory procedures. Because GIP had incomplete information, some IFCAP information for certain inventory items was also used to populate DynaMed.

We reviewed a judgment sample of 47 of 634 warehouse line items recorded in GIP on February 25, 2004. Inventory counts for 28 of the 47 (60 percent) line items were incorrect. In 14 of the 47 (30 percent) line items reviewed, the on-hand quantities were less than the recorded inventory. For the remaining 15 (32 percent) line items, on-hand quantities were higher than the recorded inventory.

In addition, we reviewed a judgment sample of 32 of 6,134 SPD line items on February 24, 2004. Inventory counts of 29 of the 32 (91 percent) line items were incorrect. In 15 of 32 (47 percent) instances, on-hand quantities were less than the recorded inventory. For the remaining 13 (41 percent) line items, on-hand quantities were higher than the recorded inventory.

In order for conversion of data to CoreFLS to be successful, GIP data needs to be accurate. Tasks such as verifying a complete supply inventory and ensuring existing inventory is assigned the correct stock item location are necessary to realizing the full benefits of CoreFLS. However at VAMC Bay Pines, GIP data were incomplete and inaccurate. We are concerned that similar conversion problems will occur at other VA facilities as the system is deployed nationwide. We examined supply inventory management practices during CAP reviews at 82 facilities since January 1999 and reported GIP deficiencies to VHA managers at 68 facilities. CAP reviews have shown that VHA SPD and A&MM needed to monitor medical supply usage, reduce excess inventory, and improve the accuracy of GIP data. FMS needed to reduce excess engineering supply inventory and develop a comprehensive plan for controlling these supplies with GIP. Prosthetic and Sensory Aids Service needed to reduce excess prosthetic inventory and improve the accuracy of Prosthetic Inventory Package data. Facilities had not used GIP automated tools

to improve accountability and controls. In addition, medical center staffs needed to reduce medical supply inventory levels to the 30-day supply goal and monitor supply usage rates.

Employees Need Sufficient Training to Use CoreFLS

Our review showed that employees did not take or complete the required e-training necessary to operate and maintain CoreFLS. Office of Management and Budget (OMB) Circular A-127 prescribes that managers will provide employees appropriate training on the use of financial management systems, based on the levels, responsibilities, and roles of individual users. The purpose of the policy is to enable users of the systems at all levels to understand, operate, and maintain applicable financial management systems.

VA CoreFLS project managers relied primarily on nine e-training modules to train their VAMC employees on CoreFLS applications and processes. The nine training modules covered the following topics: accounts payable, accounts receivable, asset management, general ledger, inventory, budgeting, fixed assets, project accounting, and purchasing.

During our visit in February 2004, we evaluated two of the nine e-training modules to determine if employees took and completed the required e-training. We selected the accounts payable and inventory curriculums for this purpose. Records reviewed showed full attendance had not been met. Key employees such as the lead accounts payable technician had not completed any of the required e-training courses and the Chief of Accounting had only taken one course activity.

We found similar results with the inventory module. Full attendance had not been met. For example a key employee, the Chief, SPD had not logged onto any of the required e-training courses.

There is a disparity between the e-training offered and instructor led classes. For example, the e-training inventory module for accounts payable procedures and processes was estimated to take 17 hours to complete. The e-training accounts receivable module was estimated to require 9 hours of instruction. In comparison, Oracle provides instructor-led courses in Federal payables and Federal receivables, both of which are 4 days in duration.

During our October 2003 visit, interviews with 10 employees identified training concerns. We were told that the training did not provide for discussions, the ability to ask questions when they were uncertain of the material, and the setting aside of designated periods of uninterrupted training time. We were told that CoreFLS project management did not provide enough workshops. Employees informed us they did not feel comfortable with the limited instruction and could not adequately use the system applications. For example, we were told invoices were on hold because employees did not understand how to remove holds and process invoices correctly.

Management Needs to Implement Prior Recommendations

During our February 2004 visit, we found that VA CoreFLS project management did not implement approximately 45 percent of the recommendations reported by ACCESS Systems Inc. (ACCESS), VA's Independent Verification and Validation (IV&V) contractor.

Software verification and validation is an important step in the system development life cycle. It assures that functional requirements are performing as intended. National Institute for Standards and Technology (NIST) Special Publication 500-234, "Reference Information for the Software Verification and Validation Process" states the major objectives of the software verification and validation process are to comprehensively analyze and test the software during development to determine that the software performs its intended functions correctly, ensure that it performs no unintended functions, and provide information about its quality and reliability.

The NIST publication also states that managerial independence of an IV&V means the responsibility belongs to an organization outside the contractor and program organizations that develop the software. Financial independence means that control of the IV&V budget is retained in an organization outside the contractor and program organization that develop the software.

VA contracted with Access Systems Inc. to provide an independent verification and validation of CoreFLS. Access Systems conducted its test from March 3 to April 11, 2003, and identified deficiencies warranting corrective actions. Access Systems made 14 recommendations designed to strengthen performance planning and testing, configuration management, test scenarios, quality assurance documents, and cost management.

During our February 2004 visit, Access Systems informed us that VA CoreFLS project management had not implemented 9 of the 14 recommendations identified in Access Systems' final report¹⁰ issued on April 30, 2003.

Access Systems independently verified and validated the operational test phase one of CoreFLS, which was planned to go operational in October 2003 at the medical center. ACCESS conducted their tests from September 7-29, 2003. Access Systems made another 21 recommendations to improve process planning and management, system functionality, and system performance. Access Systems informed us that CoreFLS project management had not implemented 7 of the 21 recommendations identified in the ACCESS report¹¹ dated September 29, 2003.

VA Employees Needed To Be More Involved in Testing Procedures

During our December 2003 visit, we became concerned that test results may not provide assurances that CoreFLS will meet VA needs after observing two tests of the system. OMB Circular A-123 states that management controls must provide reasonable assurance that assets are safeguarded against waste, loss, unauthorized use, and misappropriation.

¹⁰ "CoreFLS Quality Assurance and Independent Verification and Validation Test Results" April 30, 2003

¹¹ "CoreFLS Build 1.2 QA/IV&V Report" September 29, 2003

According to the JFMIP Forum Highlights: “System Implementation Success Factors using COTS Financial Systems, dated June 12, 2003,” qualification testing ensures a certain level of compliance with Government-wide requirements, but should be viewed as “entry criteria.” Agencies should conduct supplemental testing to ensure the financial management system meets their specific requirements, and to ensure adequate system performance.

Our observations during both “Build 1.2” and “Build 1.3” testing disclosed test results may be unreliable. In some cases, we observed BearingPoint employees rather than VA employees developing and conducting the test and determining test results. In one case we observed one VA tester who was not familiar with the business process being tested and required assistance from BearingPoint employees to perform the test.

We had particular concerns regarding performance results to support the 8 second end-to-end response time under a load across the Wide Area Network. Although progress has been made in monitoring system performance due to the use of electronic monitoring, sufficient testing has not been conducted for peak demand. The lack of sufficient performance monitoring and comprehensive analysis for bottleneck detection may result in increased costs to process financial and logistic transactions. Additionally, performance measurement and monitoring methods may not provide accurate results. For instance, we observed performance results being measured through the use of a stop watch and performance monitoring relied on employees reporting slow performance to the help desk. Some employees we interviewed stated slow response times were not always reported to the help desk.

The Project Director responded that the “Build 1.3” test plan clearly specifies that in the event designated testers are not available, CoreFLS team members will execute the test scripts. Also, the Project Director responded that in all cases they have weighed the costs of delaying testing versus the risks of continuing. These conditions add further concern that VA has limited control over the development of this system and assurances that test results have been independently verified by VA employees. In our judgment, thorough testing is necessary for optimal performance throughout the system development life cycle. Testing enables VA to ensure that the system works in accordance with expectations. The lack of reliable test results increases significantly the risk of the CoreFLS system not working effectively.

CoreFLS Needs to Interface with Other VA Medical Center Systems

Our review showed that VA CoreFLS project management has yet to successfully interface CoreFLS with all other existing medical center systems. Effective system interfaces depend on reliable data and effective electronic communications. The JFMIP “Federal Financial Management System Requirements” state that financial transactions can be originated using external feeder applications. To ensure that data can move effectively between the core financial system and other financial applications, the core system must include an application program interface to accept financial data generated by external applications. This interface must support the receipt of transactions for all core accounting components, as well as vendor information updates.

During our visit in October 2003, we identified two transactions input into the VistA and the PAID systems did not update the appropriate CoreFLS accounts. We observed similar activity during our site visit in December 2003. Two transactions input into VistA did not update the appropriate CoreFLS account. A pre-validation error message was received after the nightly batch processing. Our observations in February 2004, showed system interfaces remained unstable. For instance, we identified two transactions input into VistA did not always update the appropriate CoreFLS account. In one instance we observed a transaction that was double posted to the general ledger.

Issue 4: CoreFLS Security Controls

Summary

Employee duties and responsibilities need to be segregated and access controls need to be strengthened. VA CoreFLS project managers also need an effective contingency plan to protect CoreFLS assets and functionality. In addition, accountability controls need strengthening and application change controls need improvement.

Interim Results

VA CoreFLS Project Managers Need to Segregate Duties and Responsibilities

VA CoreFLS project managers needed to adequately separate the key duties and responsibilities of the Application Developer, System Administrator, and Security Administrator. OMB Circular A-123 states that key duties and responsibilities in authorizing, processing, recording, and reviewing official agency transactions should be separated among individuals. Managers should exercise appropriate oversight to ensure individuals do not exceed or abuse their assigned authorities. Federal Information Processing Standard (FIPS) Publication 73, published by the NIST states that separation of duties should be the assignment of each function, to the extent possible, to different individuals. It also prescribes that it is important to define each function clearly so that there will be no overlap in responsibility from one function to another.

VA CoreFLS project managers decided not to segregate the duties of contract employees because employees needed full access to deploy the system. Consequently, current conditions permit a BearingPoint employee to create transactions, process and pay the transactions, and erase the transactions. We reported this vulnerability on two separate occasions. In our November 2003 memorandum, we reported that eight contract employees had both Application Developer and System Administrator rights. In our December 2003 memorandum, we reported that nine contract employees had both Application Developer and System Administrator rights. Three of the nine contract employees had both Security Administrator and System Administrator rights. As of February 2004, five contract employees had both Application Developer and System Administrator rights and two others had both System Administrator and Security Administrator rights.

Access Controls Need Strengthening

Our review showed that VA CoreFLS project managers need to strengthen CoreFLS access controls to prevent deliberate misuse, fraudulent use, improper disclosure, or destruction of data. OMB Circular A-130 requires that program managers establish controls for determining who, and at what level, staff should have access to major application systems. Access approval is based on the principles of “need-to-know” and “least privilege.” “Need-to-know” is determined

by the individual's verified need to access information for a particular job function. The principle of "least privilege" ensures that users will only have the minimum privileges needed to carry out their duties.

NIST Special Publication 800-14, "Generally Accepted Principles and Practices for Securing Information Technology Systems" states that organizations should control access to resources based on access criteria. One access criteria is the use of user roles. Roles are used to control access by job assignment or function of the user who is seeking access. The process of defining roles should be based on a thorough analysis of how an organization operates and should include input from a wide spectrum of users in an organization.

During our October 2003 visit, we observed and were informed that VA CoreFLS project management did not assign employees access consistent with their designated roles and responsibilities. Four of 10 employee end-users interviewed were not assigned the appropriate roles and responsibilities during the initial operational test deployment at the VAMC. Two employees were granted access rights to modules outside the scope of their responsibilities. Employees were eventually provided assigned access to modules related to their job duties. Even though VA CoreFLS project managers have made improvements in developing a plan to correct assigning appropriate access roles and responsibilities, draft procedures remained incomplete at the time of this review. Management informed us revised procedures to strengthen these controls should be in place by May 2004.

VA CoreFLS Project Managers Need an Effective Contingency Plan to Protect Assets and Functionality

Our review showed that VA CoreFLS project managers may not be able to recover CoreFLS operational capability in a timely, orderly manner or perform essential functions during an emergency or other situation that may disrupt normal operations. OMB Circular A-130, "Management of Federal Information Resources," Appendix III states a contingency plan shall be established and periodically tested to perform the agency function supported by the application in the event of failure of its automated support. The NIST Special Publication 800-34, "Contingency Planning Guide for Information Technology Systems," provides guidance for Government information technology contingency planning.

While VA CoreFLS project managers followed a sample format provided by existing criteria, we found the plan to be incomplete. The plan did not contain sufficient detailed roles, responsibilities, teams, and procedures associated with restoring the system following a disruption or disaster. VA CoreFLS project managers did not include key elements identified in the "Contingency Planning Guide for Information Technology Systems."

To illustrate, VA CoreFLS project managers did not have in place adequate notification and recovery procedures. VA CoreFLS project managers need a sound notification phase built into their plan that describes the process of notifying recovery personnel and performing damage assessments. VA CoreFLS project managers also need an effective recovery phase built into the plan that discusses a suggested course of action for recovery teams to restore operations at an

alternate site, or how best to use contingency capabilities. The reconstitution phase outlines actions that can be taken to return the system to normal operating status.

We found that notification procedures did not describe the methods used to notify recovery personnel and identify all essential recovery personnel. VA CoreFLS project managers did not identify in the plan a damage assessment team leader and contingency plan coordinator and the plan did not discuss procedures to follow if an individual could not be contacted. Recovery activities focus on contingency measures to execute temporary processing capabilities, repair damage to the original system, and restore operational capabilities at the original or new facility. The contingency plan did not include recovery procedures written in a step-by-step sequential format so system components could be restored in a logical manner. The plan did not include instructions on how to coordinate with other teams and it did not include procedures to designate the appropriate team to coordinate shipment of equipment, data, and vital records. The plan did not include an arrangement for an alternate data processing and telecommunications facility. Plans must take into consideration non-traditional disasters that include massive regional power blackouts and terrorist strikes in the magnitude of the events of September 11, 2001. Finally, VA needs to test the plan to ensure it effectively protects the system and applicable fiscal and acquisition processes. The lack of a complete and tested contingency plan could affect mission critical operations if processing capability were to be lost.

The VA CoreFLS Project Director was aware of the importance of contingency planning and informed us that he has planned to update and test the contingency plan during the course of operational testing. However, we reported this condition to VA CoreFLS project managers after our October, November, and December 2003 visits. As of March 2004, contingency planning requirements remain incomplete.

Accountability Controls Need Strengthening

Our review showed that VA CoreFLS project managers needed to add sufficient safeguards (audit trails) to monitor the CoreFLS system. NIST Special Publication 800-12, "Introduction to Computer Security: The NIST Handbook," provides advice and guidance related to application-level audit trails. It states that audit trails can provide a means to help accomplish several security-related objectives, including individual accountability, reconstruction of events, intrusion detection, and problem analysis. By advising users that they are personally accountable for their actions, which are tracked by an audit trail that logs user activities, managers can help promote proper user behavior. Users are less likely to attempt to circumvent security policies if they know that their actions will be recorded in an audit log.

In general, application-level audit trails monitor and log user activities, including data files opened and closed, specific actions, such as reading, editing, and deleting records or fields, and printing reports. Technical-level audit trails monitor and log user access. In our opinion, the risk of unauthorized transactions is currently high due to the large number of non-VA users that have access to the production application. For instance, as of February 2004, a total of 60 contract employees had access rights to the production application. We believe the risk factor is also high

because VA CoreFLS project managers have not implemented procedures to review and monitor audit logs to detect a pattern of access that would indicate a problem.

Application Change Controls Require Improvement

Our review disclosed the VA CoreFLS project management did not follow its internal procedures governing the authorization of software changes. The Federal Information System Controls Audit Manual (FISCAM) published by the General Accounting Office states that establishing controls over the modification of application software programs helps to ensure that only authorized programs and authorized modifications are implemented. This is accomplished by instituting policies, procedures, and techniques that help ensure all programs and program modifications are properly authorized, tested, and approved and that access to, and the distribution of, programs is carefully controlled. Without proper controls, there is a risk that security features could be inadvertently or deliberately omitted or “turned off” or that processing irregularities or malicious codes could be introduced.

For example:

- a knowledgeable programmer could surreptitiously modify program codes to provide a means of bypassing controls to gain access to sensitive data;
- the wrong version of a program could be implemented, thereby perpetuating outdated or erroneous processing that is assumed to have been updated; or
- a virus could be introduced, inadvertently or intentionally, that disrupts processing.

Procedures require Configuration Control Board (CCB) approval for change requests exceeding \$100,000 for baseline code and technical environment changes. The CCB includes representatives from VHA, VBA, NCA, and the Office of Management. A project official stated cost estimates for changes have not been developed and the use of the CCB has not been implemented.

Our review showed that the VA CoreFLS project management needs to provide assurances that software modifications are properly authorized and approved as specified in their policy document. Our review showed that project VA CoreFLS project managers did not obtain the necessary authorizations to make software changes as specified in the “(CCB) Charter and Procedures” document. Also, this document lacked procedures for testing software modifications and obtaining CCB approval based on test results. Because procedures were incomplete and not followed there is no assurance that the implementation of 89 software extensions and approximately 630 other major modifications were appropriate.

Issue 5: CoreFLS Contract Procedures

Summary

Our review shows systemic weaknesses in the contracting process with respect to the task orders issued to the primary contractor. We have not reached a conclusion as to what effect these weaknesses had on VA getting the right product at the right price in a timely manner. We found that the contract files were poorly organized and did not contain complete project documentation. We have requested information from the OA&MM to determine if the missing documentation either was not made part of the official contract file or if it was never prepared.

We have identified the following concerns:

- The original request for proposal (RFP) and basis of award documentation could not be located in the contract files provided.
- Several independent Government cost estimates were missing.
- Technical evaluations were not adequate or non-existent.
- There was no evidence that price reductions were requested.
- Authorships of “Statements of Work” are in question.

Interim Results

Basis of Award

Under Phase I, VA contracted with Booz Allen Hamilton to develop high level user requirements, conduct a market survey, conduct a proof of concept laboratory of candidate COTS Federal financial systems, and obtain approval of a capital investment proposal for the CoreFLS solution. VA then sought an integration partner to provide subject matter expertise to assist the CoreFLS project team in three areas defined as Phase 2, 3, and 4. Phase 2 included providing expert advice to the CoreFLS project team and participation in business process reengineering, information technology assessment, functional and technical requirements definition, and acquisition planning for a CoreFLS solution. Phase 3 was for expert advice for acquisition of a CoreFLS solution. Phase 4 was for expert advice for prototyping and implementing a replacement integrated financial and logistics CoreFLS solution.

VA awarded the initial task order, G07037, titled “Integration Effort in Support of CoreFLS Phase 2” to BearingPoint in the amount of \$750,165. From our review of the contract files, we could not locate the original RFP, nor could we determine on what basis VA made the award to BearingPoint over the other offerors. The absence of the RFP hampers our efforts to establish exactly what product the Government was contracted for. We have requested the RFP from OA&MM and once we review it, we will be able to render an opinion as to whether the decision to award to BearingPoint was supported by sound contracting practices. We have identified 20 task orders valued at approximately \$119.2 million. These task orders appear to cover

integration efforts of all three phases, as well as specific tasks requirements defined within the scope of the phases.

Independent Government Cost Estimates

The task order files generally lacked an independent Government cost estimate. The preparation of independent Government cost estimates after completion of the draft statement of work is an inherent part of sound contract management and administration. The independent Government cost estimate should include an estimate for the total costs to complete the tasks as identified in the draft statement of work, an estimate of hours by task broken out by labor category (skill mix), and an estimate for other direct costs, such as travel expected to be incurred.

Ultimately, the contractor's proposed work plan and costs are compared against the independent Government cost estimate. VA's project officer and contracting officer are responsible for reviewing the contractor's work plan and costs to ensure that all tasks in the statement of work are addressed and that the proposed hours and labor categories (skill mix) meet the Government's requirements.

Of the eight task order files we reviewed to date, only two contained independent Government cost estimates. Furthermore, these two estimates were dated the same day as the contractor's proposals and were for the same amounts proposed by the contractor. From the documentation in the file, it appears that the cost estimates were not prepared prior to issuance of the statement of work and were not prepared independently. This represents a lack of control over the contract's task order process.

Technical Evaluations

Technical evaluations of task orders either were inadequate or nonexistent. A technical evaluation should be conducted on each work plan to rate how the contractor will accomplish the proposed task order. The technical evaluation is the VA project officer's responsibility and should address the qualitative and quantitative aspects of the contractor's proposed work plan. The technical evaluation specifically should address whether the contractor's proposed hours and skill mix are adequate to complete the proposed tasks effectively and efficiently. The technical evaluation should determine if the proposed skill mix is necessary to complete the proposed tasks with particular focus on evaluating whether high-end labor categories are technically necessary, particularly on a firm-fixed price task order.

We found documentation of technical reviews for four of the eight task orders. The technical evaluations consisted of a proforma evaluation in a check-the-box format containing the following four options: agree with the technical approach; non-concur with the technical approach; concur with the proposed hours and skill mix; or non-concur with the proposed hours and skill mix.

All four technical evaluations received the same ratings of agree with the technical approach and concur with the proposed hour and skill mix. The contracting officer's technical representative (COTR) did not make any additional comments on the strengths or weaknesses of any of the four

technical evaluations. It appears that the work plans proposed by the contactor were accepted without any detailed review or comment, representing a weakness in contract administration and management functions.

Limited Price Reductions

All eight task orders we reviewed to date have exceeded the maximum order threshold. Section 8.404 (b)(3) of the Federal Acquisition Regulation (FAR) dealing with using Federal Supply Schedules (FSS) states each schedule contract has an established maximum order threshold, representing the point at which it is advantageous for the ordering office to seek a price reduction.

The maximum order threshold for the Federal Supply Class Group 70 contract (IT Services) is generally \$500,000. We noted that BearingPoint gave a voluntary price reduction of 35 percent off of their GSA schedule contract rates for the initial task order issue under Task 1 of the project. The value of the initial task order after modification was \$750,165. Our review of the other seven task orders reviewed to date indicated that the contracting officer requested a price reduction only once. The contactor refused to provide any price reductions stating that their GSA rates were already discounted 30 percent. No further argument by VA is noted in the file.

Authorship of Statements of Work are in Question

We found in the contract files 12 “Statements of Work” for 20 identified task orders. Missing records and gaps in the documentation prevented us from locating the statements of work for the remaining task order modifications. We also could not determine who authored the statements of work.

Statements of work should outline the tasks to be performed and enable contracting authorities to assess the contractor’s work performance against measurable performance standards (FAR Subpart 37.602-1). They serve as the contracting authority’s measurement tool to ensure the Government receives a quality product. Statements of work are usually produced by a collaboration of technical and administrative personnel who are familiar with the project and contracting regulations. These individuals are responsible for ensuring that VA’s objective of receiving a quality product in the desired time frame at the best price is met.

We could not ascertain with certainty who prepared the 12 statements of work. It appears from our preliminary analysis that the verbiage and format were either exact or quite similar to the contractor’s proposal. In at least one instance, we discovered that sections of both the statement of work and BearingPoint’s proposal were identical. This discovery is troublesome because either BearingPoint was actually the author of the statement of work or VA accepted a regurgitation of VA’s “Statement of Work” as an acceptable technical proposal.

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