



Department of Veterans Affairs

Office of Inspector General

**Issues at VA Medical Center Bay Pines,
Florida and Procurement and
Deployment of the Core Financial and
Logistics System (CoreFLS)**

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Executive Summary

Introduction

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducted an evaluation of selected patient care and administrative issues at the Bay Pines VA Medical Center (BPVAMC), Bay Pines, Florida. The evaluation also included reviews of VA Central Office contract procedures and the deployment of the Core Financial and Logistics System (CoreFLS).

The VA Secretary, Members of Congress, and other stakeholders requested that the OIG review reported delays in elective surgeries, major shortages of surgical supplies, and other allegations concerning BPVAMC activities; and whether the deployment of CoreFLS contributed to these reported problems. The VA Secretary also requested a private contractor to determine the viability of the CoreFLS software package to accomplish expected goals.

On March 19, 2004, the OIG issued, *Interim Report – Patient Care and Administrative Issues at VA Medical Center Bay Pines, FL* (Report Number 04-01371-108), which addressed cancelled and delayed surgeries; Supply, Processing, and Distribution (SPD) deficiencies; deployment of CoreFLS; and CoreFLS contract procedures and security controls. To view this report, click on the following website link:

<http://www.va.gov/oig/52/reports/2004/VAOIG-04-01371-108.pdf>

The purpose of this review was to further address the concerns identified in the OIG Interim Report, as well as to review additional issues brought to our attention.

Results

We confirmed reports of substandard patient care and services at the BPVAMC, and found that many of the conditions existed prior to the deployment of CoreFLS. We concluded that the contracting and monitoring of the CoreFLS project was not adequate, and the deployment of CoreFLS encountered multiple problems. Even though VA has obligated \$249 million of the \$472 million budgeted for CoreFLS, it has not been successfully deployed at a VA medical facility.

The success of CoreFLS is highly dependent on the ability of the software to integrate with existing VA legacy systems. Therefore, it is essential that existing VA legacy systems and associated applications, such as the Veterans Health Information Systems and Technology Architecture (VistA) and the Generic Inventory Package (GIP), are properly implemented and maintained at all VA medical facilities. We found that most

of the VA legacy systems at BPVAMC contained inaccurate data because they had not been used properly, and that this may be a systemic problem throughout the Veterans Health Administration (VHA). The effect of transferring inaccurate data to CoreFLS interrupted patient care and medical center operations. We are concerned that similar conversion problems will occur at other VA facilities if the conditions identified at the BPVAMC are not addressed and resolved nationwide. The following conditions were identified during the evaluation.

Issue 1: Inadequate BPVAMC Management Resulted in Dysfunctional Clinical and Administrative Operations

- Turnover in key leadership positions was excessive, lack of trust in senior leadership led to low physician and employee morale, management failed to take the steps required to lead BPVAMC through the challenges of an increasing workload over the past 5 years, and the former Chief, Medicine Service created a hostile work environment and misused funds.
- In many areas of BPVAMC, a culture-of-safety and accountability was not evident. Communication that was important for patient safety was not discussed out of fear of adverse consequences. Management did not have in place a formal Administrative Executive Board for raising and resolving problems.
- Audiology appointments were manipulated by management to meet performance goals, resulting in waiting lists being understated by more than 1,000 veterans. Service-connected veterans were not receiving appointments within the 30-day requirement, and nonservice-connected veterans had their appointments cancelled, with some waiting in excess of 800 days.
- A loss-of-oxygen incident at the facility raised management, safety, contracting, and compliance concerns.

Issue 2: Medical Care in Selected Clinical Services was not Adequate

- The Radiology Service was not able to schedule or interpret x-ray images within acceptable time frames. On February 24, 2004, there were 1,099 unread x-rays, over 750 of which were Computerized Tomography scans and Magnetic Resonance Imaging (MRI) films. These delays contributed to delays in diagnosing patients with lung cancer. We cite an additional case where the delay in MRI interpretation and the diagnosis of a tumor, contributed to a veteran's spinal cord injury.

- The absence of an established, workable system to obtain medical services not available at BPVAMC, such as neurosurgery services, contributed to unacceptable delays in transferring patients for needed services. For example, we document that eight physicians were called in an attempt to transfer one patient from the BPVAMC emergency room to a Neurosurgery Service at another facility.
- Pulmonary Service patients incurred unexplained appointment cancellations, and there was insufficient medical input into referral of patients for sleep studies. The Dermatology Service procedure room did not meet environmental standards, and Medicine Service did not have a peer review process to monitor patient care.

Issue 3: VA's Management of the CoreFLS Project did not Protect the Interests of the Government

- In 1999 BearingPoint was competitively awarded the CoreFLS project for \$750,165, even though the budgeted project cost was \$372 million. Since then, VA non-competitively awarded BearingPoint 22 task orders through March 2004, totaling \$116.5 million. The budgeted project cost has escalated to \$472 million.
- A major concern with the sole-source award of the 22 task orders was that BearingPoint developed the statements of work and cost estimates that were accepted by VA without any independent evaluation of need or reasonableness, which was tantamount to issuing BearingPoint a blank check.
- Volume purchase discounts valued at \$19.1 million were not pursued by the contracting officer due to confusion on the part of VA concerning the project phase. Also, BearingPoint was paid an award fee of \$227,620, even though they did not successfully implement CoreFLS at BPVAMC.
- Task orders and modifications were routinely awarded and funded by VA without sufficient justification and required documentation. BearingPoint was allowed to perform work and purchase software without prior approval for which they were later fully compensated. In one instance, software totaling \$627,000 was purchased without a proper task order or approved modification.
- Contractor travel costs totaling about \$4.2 million were not adequately monitored or reviewed for compliance with task order provisions and Federal travel regulations. Planning was not adequate to control costs. Travel vouchers lacked justification for excessive airfares for frequent repetitive trips. Vouchers usually did not indicate the purpose and necessity of travel.

- The lack of background investigations for BearingPoint employees after 4 years into the CoreFLS project increased VA's risk that computer systems and sensitive data could have been compromised.

Issue 4: BPVAMC was not Adequately Prepared for CoreFLS Deployment

- CoreFLS was deployed for testing at BPVAMC on October 6, 2003, without sufficiently resolving numerous OIG reported risks, including inadequate training to prepare hospital employees on how to use CoreFLS, and concerns related to not using a parallel processing system when several risks still remained.
- Failure to run a parallel system, as recommended by the OIG prior to deployment, resulted in unnecessary risk to patient care and the inability to monitor fiscal and acquisition operations. As a result, BPVAMC could not reconcile accounts.
- VA CoreFLS project management also failed to address additional concerns reported by the OIG on November 12, 2003, involving data conversion and system interfacing issues. For example, VA project management responsible for converting CoreFLS related data did not confirm the accuracy of the applicable legacy system data prior to testing, resulting in failed conversion tests and higher costs associated with reconciling problems.
- While some legacy systems that CoreFLS is designed to interface with did not contain accurate data, some applications such as GIP were not in use prior to testing. CoreFLS cannot be tested adequately until all systems and applications that interface with CoreFLS are properly implemented and accurately maintained.

Issue 5: CoreFLS Security Weaknesses Placed Programs and Data at Risk

- Duties and responsibilities of CoreFLS administrators were not segregated, thereby creating a control weakness that would allow administrators to create, process, and erase transactions. Without segregating system administrator rights, individuals also could disable audit trails and purge information from the database.
- Employees were not assigned access to CoreFLS programs consistent with their responsibilities. Strengthening employee access controls is needed to prevent deliberate misuse, fraudulent use, improper disclosure, or destruction of data.
- Because CoreFLS managers did not have an effective contingency plan to protect CoreFLS assets and functionality, they may not be able to recover CoreFLS operational capability in a timely, orderly manner or perform essential functions during an emergency or other event that may disrupt normal operations.

- Because CoreFLS managers did not properly follow procedures governing the authorization of software changes, there was no assurance that implementation of 89 software extensions and 630 major modifications during system development was appropriate. Also, provisions for software upgrades were not provided for.

Issue 6: Senior Leadership did not Respond Adequately to SPD Warnings and did not Ensure Adequate Preparation for CoreFLS Testing

- SPD staff were unable to provide sterile equipment and needed supplies to the operating room resulting in the cancellation of 81 elective surgeries for a week in November 2003 and February 2004. In addition, the operating room was forced to operate at two thirds of its prior capacity. We cite three cases with post operative infections that, because of their unusual nature, are possibly the result of improper instrument sterilization.
- The volume of procurement activity, combined with the absence of controls and questionable acquisition practices, raised serious concerns as to whether all supplies acquired by SPD arrived at the hospital and were available for patient care.
- SPD policies and procedures were not documented, inventories were not secured, and required annual inventories were not conducted. Inaccurate inventory records resulted in overstatements of stock on hand. For example, we found one item overstated by at least \$2.3 million.
- In spite of repeated notices by VHA of the need for an efficient inventory management program, BPVAMC did not fully or adequately implement GIP to manage inventories. Consequently, conversion of inventory data to CoreFLS failed.
- Our Combined Assessment Program (CAP) reviews identified GIP deficiencies at 68 other VA medical facilities. Without an inventory management system that ensures databases are populated with consistent and accurate data, CoreFLS cannot be properly tested or deployed throughout VHA.
- Fiscal Service was unable to reconcile accounts. Excessive late payment penalties have occurred, and as of April 28, 2004, there were invoices valued at about \$808,000 on hold for reasons such as they could not be matched with purchase orders, and some checks were returned to the Treasury because of bad addresses or erroneous vendor information.

We made a number of recommendations to improve clinical and administrative controls and take certain actions at the BPVAMC. Given the CoreFLS issues identified thus far, neither BearingPoint nor any other vendor should be awarded any additional task orders after the current task order expires June 30, 2004. Based on our findings, combined with the results of the private contractor's software technical assessment, VA leadership needs to consider whether the CoreFLS project can meet the needs of the Department or should be ended. If CoreFLS can meet the needs of the Department, VA should develop a comprehensive Statement of Work, and compete the requirement. VA should also ensure that it has the technical expertise to manage the project, and that all facilities have certified the accuracy and reliability of all VA legacy systems and data that will be integrated with CoreFLS so conversion problems encountered at BPVAMC do not occur at other sites.

Comments

The Acting Under Secretary for Health, Deputy Under Secretary for Operations and Management, VISN and BPVAMC Directors, Acting Assistant Secretary for Management, Assistant Secretary for Information and Technology, and Acting Assistant Secretary for Policy, Planning, and Preparedness concurred with the recommendations and provided acceptable implementation plans. We will continue to follow-up on all planned actions until all of the issues have been resolved.

(original signed by:)
MICHAEL L. STALEY
Assistant Inspector General for Auditing

(original signed by:)
JOHN D. DAIGH JR., MD, CPA
Assistant Inspector General for
Healthcare Inspections

(original signed by:)
DANIEL PETROLE
Assistant Inspector General for Investigations

Introduction

Purpose

In March 2004, the OIG reported on patient care and administrative issues at the BPVAMC. We addressed cancelled and delayed surgeries, SPD Section deficiencies, VA's deployment of the CoreFLS, CoreFLS security controls, and CoreFLS contract procedures. There continues to be intense VA Secretarial, Congressional, and veterans' service organization concern about these issues.

The purpose of this evaluation was to further address the issues and concerns identified in *Interim Report – Patient Care and Administrative Issues at VA Medical Center Bay Pines, FL* (Report Number 04-01371-108, March 19, 2004), as well as to review additional issues and concerns identified by VA's Secretary, Members of Congress, veterans' service organizations, BPVAMC employees, and during OIG site visits.

Background

Requests for OIG Review

The issues at BPVAMC prompted Congressional hearings and numerous calls for OIG review. The Secretary of Veterans Affairs had requested that the OIG review operations at the medical center in early February 2004. On February 4, 2004, the House Committee on Veterans' Affairs raised questions about CoreFLS. On February 19, 2004, Congressman Steve Buyer requested that the OIG conduct a review of the ongoing implementation of the CoreFLS program at the BPVAMC. Senator Bob Graham, 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. 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. The VA Deputy Secretary visited BPVAMC on February 23, 2004, as well. On February 25, 2004, Congressman Lane Evans requested that the OIG review the conditions at BPVAMC.

Also in February 2004, we received inquiries from the House Veterans' Affairs Committee, Office of Oversight and Investigations, and 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. On March 22, 2004, the Senate Committee on Veterans' Affairs held hearings on the state of health care at the BPVAMC. VA entered into an agreement with Carnegie Mellon to review the technical feasibility of the CoreFLS project on April 2, 2004.

General Overview

The BPVAMC is one of six VA medical centers in Veterans Integrated Service Network (VISN) 8.¹ The BPVAMC is located in Pinellas County and it serves veterans in a 10-county area of southwestern and south-central Florida. The James A. Haley VAMC (Haley VAMC) in Tampa, FL is located 36 miles from the BPVAMC. However, the two VAMCs serve substantially different populations. The BPVAMC focuses on western Florida, while the Haley VAMC is located in Hillsborough County and serves veterans in metropolitan Tampa and Central Florida. Both are affiliated with the University of South Florida College of Medicine, with the BPVAMC relying upon the Haley VAMC as a referral site for some medical and surgical specialties.

BPVAMC has a 31-building 337-acre campus and is the parent facility for a large outpatient center in Ft. Myers, seven VA Community Based Outpatient Clinics in Avon Park, Dunedin, Ellenton, Naples, Port Charlotte, Sarasota, and Saint Petersburg, and two veterans' centers in Sarasota and Saint Petersburg. BPVAMC operates 469 beds, including a 104-bed domiciliary and 142-bed nursing home. It is a general medical and surgical facility, organized along the Product/Service line concept. BPVAMC describes its mission as providing, "...a full continuum of high quality, patient-focused healthcare to veterans" and its vision as becoming, "the healthcare provider of choice for veterans."

Workload and Demographics

While the total veteran population in the U.S. and Puerto Rico declined by 3.9 percent from 27,619,205 veterans in 1990 to 26,549,704 veterans in 2000 (net decrease of 1,069,501 veterans), the states, counties, and Congressional districts served by VISN 8 exhibited veteran population growth that was strongly opposite this larger national trend. All of VISN 8's medical centers, including the BPVAMC, have had to adjust to this explosive growth. In the process, VISN 8 has become the busiest of VA's 21 VISNs.

For example, the BPVAMC's experience with the impact of this population growth (along with national policy changes in eligibility criteria and outreach for veteran patients) is reflected by the increase in its outpatient workload. Moreover, while

¹ The information contained in the background section of this report was obtained from VISN 8, the BPVAMC, VA website, field hearing testimonies, and other sources.

inpatient workload decreased during this same time period, its decrease was not of the magnitude of the corresponding outpatient workload increase. This workload trend may be seen graphically in the following chart:

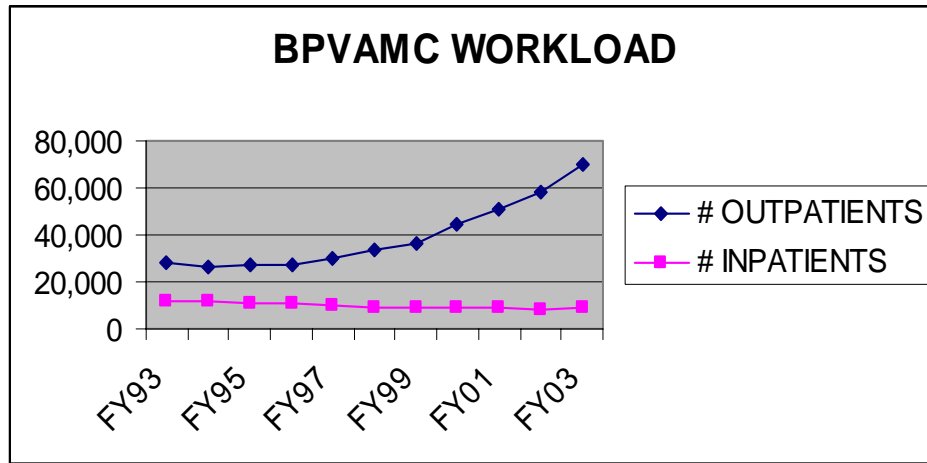


Figure I. Inpatient and outpatient workload, expressed as numbers of unique veteran patients seen by the BPVAMC, 1993-2003.

This trend has continued from the end of the last decennial census to the present. For example, in consideration of the time period after the most recent U.S. census, from 2000-2003, BPVAMC experienced a 69 percent increase in unique patients. It provided care to 49,753 unique patients in FY 2000, and to 84,089 unique patients in FY 2003. From FY 2002 to FY 2003 alone, the BPVAMC had a 20 percent increase in unique patients (70,215 patients to 84,089 patients). As such, this was the largest workload increase in VISN 8. In addition to direct patient care workload at the BPVAMC, the medical center also provides fee-basis care for almost 250,000 patient visits/year, the largest statewide fee-basis care program in the U.S.

Just as this growth in outpatient workload has only been partially offset by a decrease in inpatient workload, it has also not been matched with a proportionate increase in physician staff. For example, physician Full Time Equivalent Employees (FTE) have only increased incrementally during this same time period, as the chart in Figure II demonstrates.

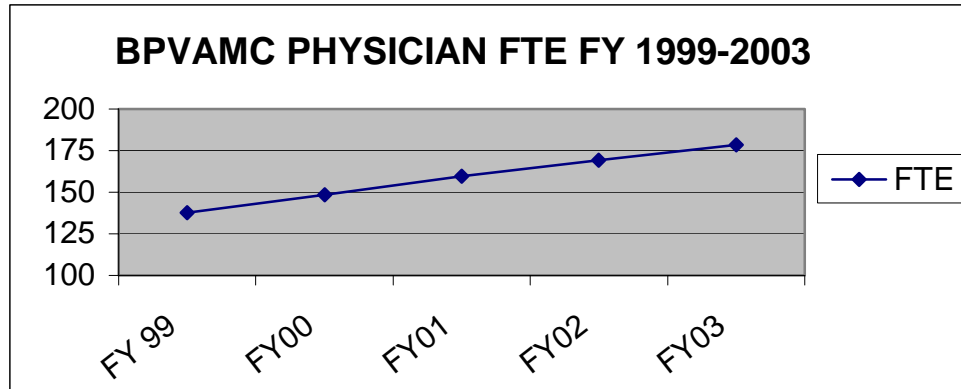


Figure II. BPVAMC total physician FTE, 1999-2003.

Prior Inspections and Reviews

Clinical Issues

In January 2003, the OIG performed a CAP review of the BPVAMC, which concluded that, “Patient care activities reviewed were generally operating satisfactorily.” However, there were opportunities for improvement in controlled substances security, control of and accountability for replenishing crash carts, safety and cleanliness of some medical center areas, controls over the Government Purchase Card Program, and automated information systems security.

In August 2003, a new Director was appointed. He testified to Congress that shortly after his arrival at the BPVAMC it became apparent that there were significant issues concerning morale and leadership within the Medicine Service. In an October 17, 2003, memorandum to the Director, a group calling itself “Members of the Medical Staff, BPVAMC,” requested a “Board of Investigation” to investigate alleged serious clinical and administrative issues at the BPVAMC. The group alleged unsafe patterns of medical care that were beneath community standards; failure to make timely appointments to fill critical medical center positions; delays in diagnosis and treatment due to problems with radiology services; the BPVAMC Chief of Staff (COS) made appointments to leadership positions in an arbitrary manner, with resultant negative impact on clinical and administrative operations and morale; the COS condoned and supported inappropriate, illegal, and unethical actions by a BPVAMC contract employee; the COS unwisely appointed one service chief to manage three departments (Nuclear Medicine, Laboratory Services, and Radiology); the COS made inappropriate productivity demands on staff; the COS adversely affected veteran patients’ health care by engaging in arbitrary and illegal actions; and the COS engaged in a pattern of harassment against VA employees, and illegal personal favoritism in personnel actions.

In a memorandum dated January 23, 2004, the VISN 8 Network Director appointed a review team. This team was charged with conducting an independent review at the

BPVAMC to, “Improve the quality of health care and to improve the utilization of healthcare resources at this VA healthcare facility...[and] review and evaluate issues related to a letter sent to the Medical Center Director.”

The VISN 8 review team consisted of four senior VISN 8 clinical managers. The team visited the BPVAMC on January 26-28, 2004, and produced Quality Assurance Review and Administrative Board Review reports. At the conclusion of the site visit, the team briefed the BPVAMC Director and the VISN 8 Director on their findings. The final reports were sent to the VISN 8 Director on February 20, 2004.

In its administrative review, the VISN team found substantial leadership and morale issues at the medical center. Their report states, “It was clear that the medical staff is in crisis. Members of the medical staff are deeply divided into groups supporting or opposing the Chief of Staff. A number of individuals from both groups expressed fear of retaliation from the other group.” Changes, fluctuations, and absence of key service chiefs were felt to be critical elements contributing to this environment.

The team found that at the service (i.e., departmental) level, regular staff meetings addressing key issues and performance metrics often appeared to be lacking. They also found a lack of effective communication among the medical staff. The team noted that regular service meetings and service meeting minutes were sporadic, and communications regarding new programs and ongoing developments were insufficient. The VISN team made extensive recommendations.

CoreFLS Issues

VA contracted with BearingPoint to integrate CoreFLS, a system designed to provide VA facilities with 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 information sharing between related systems.

As far back as the audit of VA’s FY 1991 consolidated financial statements, we have reported on VA’s need for an integrated financial management system. We reported this issue as a long-standing material weakness in our 2003 consolidated financial statement audit.²

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 in VA. The system consists of “Oracle Financials” for accounting,

² “Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2003 and 2002” Report No. 03-01237-21, dated November 14, 2003.

budget, contracting, and purchasing; Maximo³ for asset management; and DynaMed⁴ for inventory. Planning for a new integrated financial management system began in 1998. The major interfaces of the system include applications in VistA such as Accounts Receivable, Fee Basis, Decision Support System, and Prosthetics; and PAID. These legacy systems contain numerous applications. The new system will also eliminate applications such as FMS and IFCAP, which contains GIP.

In August 2000, VA selected Oracle Corporation from among seven vendors to demonstrate its software products in a pilot program. The pilot was completed on December 15, 2000. CoreFLS was then tested at VAMC Fayetteville, NC from November 5, 2001, through December 20, 2001. 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 that needed to be corrected using software extensions (extensions are modifications to software code). The extensions facilitated tailoring the basic COTS system to meet VA's anticipated requirements.

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

A meeting of the VA CoreFLS Executive Project Committee members consisting of senior leadership in VA Central Office (VACO) was held in June 2002. At the meeting, CoreFLS project management requested and received approval for the new "Go Forward Strategy Update" at BPVAMC, the mandatory top 10 extensions for development, and commitment for the additional funding. The first project phase, called Build 1.1, was tested from October 2002 through March 2003.

In December 2002, the former Under Secretary for Health and the Assistant Secretary for Management signed a Memorandum of Understanding (MOU) agreeing to fund CoreFLS and to designate BPVAMC as a test site. From May 2003 through July 2003, CoreFLS Integrated Test Cycles (ITCs) were conducted at the medical center. The purpose of ITCs was to validate the software by simulating actual business processes in a controlled environment using predefined test scripts. From August 4, 2003, through September 5, 2003, the second project phase, called Build 1.2, was tested at BPVAMC, the Florida

³ Maximo is the software for asset management and maintenance.

⁴ DynaMed is a registered trademark of and published by Dynamic Medical Information Systems.

National Cemetery, the VBA Regional Office St. Louis, the VA Financial Services Center, the VA Austin Automation Center, and VACO. On October 6, 2003, CoreFLS was implemented in “Operational Test Phase 1” at BPVAMC, St. Louis, and the Florida National Cemetery.

The total budgeted CoreFLS cost is \$472 million. According to the VA Chief Financial Officer, as of February 29, 2004, VA had obligated about \$249 million. As of January 2004, BearingPoint charged about \$4 million per month. We recently learned that from late April 2004 to late June 2004, charges are estimated to total about \$6 million.

In October 2003, as part of our continuing financial audit activities, we began reporting high risks associated with the CoreFLS deployment at BPVAMC. We observed this deployment during site visits to BPVAMC in August, October, and December 2003 and in February 2004. We briefed the CoreFLS Project Director and in October, November, and December 2003 issued memorandum reports on our observations and received written responses from the Project Director (See Appendices D, E, and F).

On October 2, 2003,⁵ we reported to the Assistant Secretary for Management and the CoreFLS Project Director our concern about not using parallel processing when several risks had not been mitigated. We also reported unmitigated risks associated with incomplete and untested service contingency plans, incomplete comprehensive roll back plans, inadequate training to prepare employees to use CoreFLS, unreliable test procedures and results, and unsubstantiated performance results. On October 6, 2003, the Project Director deployed CoreFLS at BPVAMC without mitigating any of these risks. As described in the body of this report, this decision proved to be a major, and extremely costly, error.

On November 12, 2003,⁶ we reported to the Assistant Secretary for Management and the CoreFLS Project Director the continued risks associated with the CoreFLS implementation. There were 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 when making future deployment decisions.

At the request of the Assistant Secretary for Management, we conducted a follow-up evaluation to determine if reported risks had been mitigated. On December 23, 2003,⁷ we reported that previously identified risks had not been mitigated. The Project Director

⁵ Evaluation of Transition Risks Associated with CoreFLS Build 1.2, dated October 2, 2003.

⁶ Evaluation of Deployment Risks Associated with CoreFLS Build 1.2, dated November 12, 2003.

⁷ Follow-up Evaluation of Deployment Risks Associated with CoreFLS Build 1.2, dated December 23, 2003.

responded that project-wide risks were being constantly reviewed and mitigation actions were being put in place for all known high-risk areas.⁸

On April 20, 2004, we received VA CoreFLS project management's comments to our March 2004 Interim Report. We validated the accuracy of this information prior to completing this report.

Scope and Methodology

This was a joint review conducted by OIG investigators, auditors, and health care inspectors. We reviewed operational policies, management structure and functions, and patient care delivery systems. We also reviewed extensive BPVAMC clinical, operational, and administrative documents, including quality assurance materials related to concerns about the adequacy and appropriateness of clinical care. In this process, we reviewed in detail more than 100 patient medical records. We interviewed numerous medical center physicians and other clinical, administrative, and operational staff. We inspected BPVAMC clinical areas. We reviewed other investigative reports including two detailed VISN 8 reviews performed in January 2004, external VHA reviews of the BPVAMC Radiology Service and Pulmonary Section, and a VISN 8 review of a January 2004 incident of unexpected oxygen loss.

We reviewed surgery cancellations, Radiology Service operations, cardiac catheterization patient outcomes, urology staffing, neurosurgery transfers, pulmonary services, sleep studies workload, the dermatology minor surgical suite, end-of-life issues, unexpected deaths, waiting lists and waiting times for outpatient care, physician and fee physician attendance and payment practices, and peer review practices.

To determine the productivity of the BPVAMC radiologists we used a Veterans Health Information Systems and Technology Architecture (VistA) based software program that calculates radiology Relative Value Units (RVUs) by applying Medicare-based weighting factors to completed workload. We applied the RVU program to completed radiology workload for the period FY 2003 and FY 2004 through March 22, 2004, to calculate an annualized RVU productivity for each medical center radiologist.

We conducted a detailed review of the contracting activity for CoreFLS at VACO. We also evaluated SPD operations and procedures and BPVAMC efforts to prepare for the deployment of CoreFLS. We reviewed management of the testing of the CoreFLS system and the effect of that testing on fiscal, logistical, and clinical care activities. We reviewed CoreFLS security controls. In addition, we reviewed workplace communication, working conditions, and productivity. We reviewed allegations that managers did not adequately process prosthetics clothing allowance claims.

⁸ OIG Memorandum on Follow-up Evaluation of Deployment Risks Associated with CoreFLS Build 1.2, dated January 12, 2004

We also reviewed 39 previous complaints (2001-2004) received through the OIG's Hotline Division to assess trends and evaluate management responses to the allegations. While on site at the BPVAMC, cases and issues were frequently brought to our attention by medical center employees. Many are addressed in this report. Some complaints referred to similar issues and were grouped together and others were not substantiated. One patient case is discussed in detail as a separate OIG report.⁹ Several clinical cases and issues were referred to VHA for peer review.

Our administrative investigative staff reviewed allegations received from BPVAMC clinicians concerning mismanagement by the Chief, Medicine Service and COS. To investigate the allegations, we took sworn, taped testimony from the former Chief, Medicine Service and former COS, and other VA employees knowledgeable of the alleged activities. We reviewed correspondence pertaining to alleged instances of harassment, documentation relating to the intended and actual use of donated funds, and personnel and time and attendance records of certain staff. We also reviewed applicable Federal regulations, and VA and Medical Center policies. We addressed concerns expressed by numerous other sources including members of the Florida Congressional delegation, members of Congressional oversight committees, and the VA Secretary and Deputy Secretary.

It should be noted that the OIG evaluation into the many allegations about the delivery of medical care and the performance of selected BPVAMC facility administrative units does not constitute a review of all of the administrative and clinical services provided by the BPVAMC. The complaints and allegations we received and investigated largely concerned individual units within the medical center's clinical and administrative structure. During this review process, in spite of the many issues identified in this report, we came in contact with many hard working, professionally competent individuals who were "going the extra mile" to ensure that veterans receive quality health care.

⁹ OIG report entitled, "Review of Quality of Care and Communication Issues, Department of Veterans Affairs Medical Center Bay Pines, Florida: Report Number 04-01371-151, dated June 4, 2004.

Results and Conclusions

Issue 1: Clinical Management and Administration

Findings

Senior leadership needed to better manage and administer facility operations and functions to ensure that BPVAMC uniformly delivered quality health care. Because this was not always accomplished, we found certain clinical and administrative operations that were dysfunctional. Factors such as leadership turnover, the absence of productivity standards, employee mistrust in leadership's ability to manage and treat them fairly, morale challenges, and a growing workload demand generated by a rapidly expanding veteran community contributed to lapses in providing timely care and ensuring administrative accountability. Many of the conditions either existed prior to the deployment of CoreFLS or were not the result of its implementation at the facility.

Turnover in Key Leadership Positions Contributed to Dysfunctional Management

The retention of senior leadership and midlevel managers in key clinical services has been problematic. Senior leadership of the BPVAMC consists of a Director, Associate Director, COS, and Nurse Executive. Since 1991, BPVAMC has had three Directors, and two Acting Directors; four COSs, and three Acting COSs; three Associate Directors (AD), one Acting AD, and various service chiefs in that role. There have also been multiple service chief vacancies in Medicine, Radiology, and Surgery.

Absence of Productivity Standards Contributed to Clinical Backlogs

BPVAMC senior leadership did not effectively communicate to the clinical staff attainable and specific productivity goals, and managers did not monitor physician productivity. For example, the Radiology Service did not monitor productivity by provider, and an external VHA consultant could not determine the Pulmonary Clinic workload. Contributing to this condition is the fact that VHA has not issued productivity standards for specialty care physicians and nurses as required by Public Law 107-135.

Interviews showed that a number of physicians employed at the BPVAMC believe that Title 38 mandates that they are expected to work only 40 hours per week, while, in fact, Title 38 requires that a full-time Title 38 physician work at least 80 hours every pay period. Further, Title 38 does not contemplate that physicians will be compensated for working more than 40 hours a week. Physicians in at least 2 services take one elective day off as compensation for "arduous duty" when they work 4 hours on Saturday and 4 hours on Sunday as regularly scheduled "call", when this does not meet the arduous duty standards.

The lack of productivity standards and a common understanding between leadership and physician staff regarding the time commitment of a full-time Title 38 physician contributed to the inability of the leadership and medical staff to arrive at an agreement regarding the resources required to accomplish the clinical mission.

Additionally, we found that the BPVAMC clinical leaders have not adequately communicated to medical staff that the clinical care of veterans and not research is the first priority of the medical center. This environment led to an unacceptable situation in which diagnoses were delayed while often the very BPVAMC medical staff that could have made these diagnoses timely were pursuing research activities.

A lack of relevant productivity data, absence of workload standards, and flawed priorities created an environment that made it difficult to achieve the medical center's mission of providing, "a full continuum of high quality, patient-focused healthcare to veterans."

BPVAMC leadership did not address the timeliness and quality of service provided in several areas of the medical center. To illustrate, we found that as of May 18, 2004, five Surgical Service specialties had elective surgeries scheduled beyond 30 days. BPVAMC managers informed us this occurred because an Operating Room (OR) had to be closed because of nurse staffing concerns and because of administrative shortcomings by the SPD Section in distributing sterile and complete surgical packages.

Radiology Service was unable to schedule patients for radiological procedures within the time frame required by its own standards. In addition, after imaging studies were obtained, there were often delays of days, weeks, or months in interpreting and "reporting out" these images. Physicians were often placed in the position of having to inappropriately classify radiology requests as "stat" or "urgent" because they believed that was the only way to obtain timely service for their patients. We also found that radiologists did not interpret mammogram films in a timely manner. We found that BPVAMC senior leadership knew, or should have known, of these radiology workload problems as far back as July 2001, yet the conditions persisted.

There were also longstanding problems in other clinical areas that remain chronically unresolved. These included an inability to obtain timely neurosurgery consultation, the inability to effectively manage the demand for sleep studies, and an inadequate Medicine Service Peer Review program. BPVAMC management's failure to resolve these clinical issues placed patients at risk.

Senior Leadership Did Not Have a Formal Administrative Executive Board Process in Place

Administratively, BPVAMC managers did not maintain adequate documentation of important meetings, action plans, and assignments to correct identified problems in SPD, nor did they thoroughly evaluate or document the outcomes of corrective actions taken by

management. In late 2003, continuing into the winter of 2004, the BPVAMC SPD staff could not reliably provide sterile equipment to the ORs and other clinical areas. For 1 week in November 2003 and again in February 2004, it was necessary to limit the main operating rooms to emergency cases only. Additionally, the ORs were placed on a restricted workload of 10 routine cases per day until the SPD section could manage the normal volume of 15 cases per day.

On March 15, 2004, we attempted to obtain the minutes for the Administrative Executive Board (AEB). We were first told that the AEB was disbanded several years ago. However, the Associate Director (AD) stated that the AEB was not disbanded and provided minutes of the AEB meetings. We found that they were not AEB minutes, but instead minutes of the Medical Executive Board. We asked the AD how she kept up with what was occurring in the services if there was no AEB structure. She informed us that she has lunch with the service chiefs once a month. The AD told us she believed formal meetings were not necessary as she sees her staff every day. The AD stated that no documentation of those meetings, topics discussed, or actions taken were maintained.

The AD later provided us a copy of VHA Directive 96-032, dated April 26, 1996, and advised that while facilities currently maintaining an AEB may continue to utilize this committee, it is not mandatory. Upon reviewing the Directive, we found that while an AEB was not a mandatory committee there is an expectation that it would be replaced with some other formal structure. This finding was consistent with the VISN 8 review team's observations.

Senior Leadership Did Not Adequately Respond to SPD Warnings and Resolve Problems

Our review of SPD activities found that it was not managed effectively, efficiently, or in compliance with VA requirements. In January 2003, the OIG reported to senior managers that crash carts did not always contain essential supplies and equipment necessary to perform life support procedures, medical instruments were not properly sterilized, and inventory controls needed strengthening. Management resisted concurring with the OIG recommendation to improve controls and accountability for crash cart replenishment. While eventually concurring with the recommendation, the condition continued to exist. In September 2003, BPVAMC internal reviews of SPD cited problems involving improperly stocked surgical case carts, unsterilized instruments, inadequate inventory levels, and a lack of focus by SPD staff. Similar problems were identified by another internal review of SPD in January 2004. Despite these repeat findings presented to SPD managers and to the AD, we found the similar problems continued to exist during this review. SPD issues are discussed in Issue 6 of this report.

Senior Leadership Did Not Ensure Suitable Site Preparation for Conversion to CoreFLS

We also found during our SPD review that senior management had not ensured suitable site preparation for the conversion to CoreFLS. In spite of repeated notices by VHA

Handbook 1761.2 of the need for an efficient inventory management program, the inventory management processes and procedures were severely deficient. Since October 2000, VHA released annual updates of this handbook to VHA field stations of VA's impending change to CoreFLS, and requiring the use of the GIP and its successor system to manage VHA inventories. BPVAMC senior managers had not ensured that an efficient inventory management program was in place prior to deployment of CoreFLS in October 2003. The absence of a reliable inventory infrastructure and legacy data would make deployment of CoreFLS impracticable. This matter is discussed in detail in Issue 4 of the report.

BPVAMC Leadership Lost the Trust of Some Physicians and Employees

We found that there was a lack of trust on the part of some of BPVAMC physicians that senior leadership would fairly and reasonably address their issues of concern. Senior leadership is responsible for ensuring BPVAMC promotes a "culture of safety" and shares a constant commitment to safety as a top-level priority. To establish an effective safety culture, senior leaders must be credible and gain their employees' trust. One important tenet of a "culture of safety" is the ability for an employee at any level to feel empowered to express a view, "against the authority gradient" without fear of adverse consequences.

On two occasions, OIG experienced incidents that suggested this aspect of a "culture of safety" is not present at the BPVAMC. In one instance, a group of BPVAMC physicians called the OIG to discuss routine scheduling and staffing issues, stating that they were fearful of discussing these issues with their appropriate supervisors. In the other instance, another physician called to express concern about a patient safety issue within his professional sphere of responsibility, with which he stated he was uncomfortable approaching his supervisors. This places patients at risk.

Hostile Work Environment and Misused Funds

We substantiated allegations that the former Chief, Medicine Service, supervised by the former COS, created a hostile work environment and misused funds which adversely affected the morale and trust in management by some of the physicians. Our Administrative Investigations Division investigated allegations of mismanagement and misconduct against the former COS, former Chief, Medicine Service, and former Chief of Cardiology at BPVAMC. We substantiated allegations that the former Chief, Medicine Service created a hostile work environment, primarily for some physicians, and that he misused funds donated to the affiliated research corporation.

This was not the first administrative investigation against the former Chief, Medicine Service. On February 4, 2004, we issued an administrative investigation report, which concluded that the former Chief of Medicine Service violated Federal and VA ethical conduct regulations by soliciting gifts of cash from pharmaceutical companies, which are

prohibited sources; by using his official position for personal gain when he sent the solicitation letters on VA letterhead, thus implying that VA sanctioned his solicitation, and asking that donations be deposited in his private foundation; and by engaging in other activities.¹⁰ In our October 3, 2003 draft of this report, we recommended appropriate administrative action be taken against the former Chief, Medicine Service, and that he be directed to return the gifts he received as a result of the solicitation. On January 20, 2004, the Network Director responded to the draft, concurring with the findings and recommendations. He noted that, effective September 1, 2003, while our investigation was on-going, the former Chief, Medicine Service was removed from that position. The VISN Director also noted that the former Chief, Medicine Service's temporary appointment expired January 12, 2004, and was not renewed. He said, therefore, no action was initiated to direct him to return the gifts he received.

We did not substantiate other allegations, and do not discuss them further in this report. The former COS is currently an attending physician at the VAMC Richmond, Virginia; the former Chief, Medicine Service is no longer a VA employee.

The Former Chief, Medicine Service Created a Hostile Work Environment. BPVAMC policy requires members of the medical staff to conduct themselves in a professional and cooperative manner, and prohibits them from engaging in disruptive behavior that creates a hostile, intimidating or offensive work environment for another individual, or engaging in harassing conduct that denigrates an individual because of certain characteristics, including age, if it unreasonably interferes with the person's work performance or adversely affects their employment opportunities. Medical staff are encouraged to report disruptive or harassing conduct to an appropriate supervisor. BPVAMC policy also requires that the COS, Medical Center Director, or their designees, investigate complaints, as warranted (VAMC Memorandum 516-98-11-1, dated March 1998) and assign responsibility for maintaining discipline to medical staff supervisors when an employee's conduct is unacceptable (VAMC Memorandum 516-99-05-17, dated November 1999).

In March 2002, shortly after the former Chief, Medicine Service assumed that position, he announced to Medicine Service staff that physicians in subspecialties and in the emergency room would have to work an extra 2 hours a day, and that he wanted section chiefs who had been in that position for more than 10 years to step down to attract the "brightest of the young people" to bring in new ideas. The former COS told us that he and the former Chief, Medicine Service had not previously discussed these initiatives. He stated he was not at the meeting to hear the former Chief, Medicine Service's announcements and no physician came to him directly to complain about them, but he had heard complaints during casual conversations with the staff. As early as April 2002,

¹⁰ "Administrative Investigation - Solicitation of Gifts and Other Ethics Issues, VA Medical Center, Bay Pines, Florida, Report 03-00815-79, dated February 4, 2004."

the former COS began receiving additional, written complaints about the former Chief, Medicine Service. For example, one member of the medical staff noted that the former Chief, Medicine Service spoke ill of physicians behind their backs, threatened to fire those who did not comply with his requests, and made statements to the effect that he knew how to make people uncomfortable. In May 2002, another medical staff member told the former COS that the former Chief, Medicine Service had expressed that he planned to remove two physicians from their jobs.

In testimony, physicians told us of feeling harassed or mistreated by the former Chief, Medicine Service beginning shortly after he arrived at the BPVAMC, and of perceiving that the former COS ignored their complaints. One section chief told us he took the former Chief, Medicine Service's announced plan to replace long-term section chiefs with younger physicians, and a statement that the former Chief, Medicine Service would help those who could not fit in to find new jobs, as threats to his employment. The physician told us he changed his appearance and started working late and issuing academic papers. He said he did not complain to the former COS because he believed the former COS was very supportive of the former Chief, Medicine Service. He told us that when a group of physicians eventually did meet with the former COS, nothing was done to address their concerns. The former Chief, Medicine Service told us that, regarding his announcement that section chiefs should step down after 10 years, he believed it was a good policy and had been an effective tool at leading universities.

Another physician told us he felt mistreated when his performance evaluation was downgraded after he told the former Chief, Medicine Service he was not retiring for a few more years. The physician said he did not report his concern because he did not want to appear to be a trouble maker and risk reprisal. He said the former Chief, Medicine Service also wanted him to convince another, older physician to retire. Regarding these two physicians, the former Chief, Medicine Service told us that, in the spring of 2002, the former COS instructed him to offer them an opportunity for early retirement because he wanted to replace them, both part-time physicians, with a full-time physician. He said the former COS also instructed him to offer early retirement to two other physicians who the former COS commented were not keeping up with modern medical practices. The former COS denied to us that he gave such instructions to the former Chief, Medicine Service.

A third physician told us the former Chief, Medicine Service harassed him by denying his request for military leave, and advising him that he needed to either quit the reserves or resign from the BPVAMC. The physician told us he reported this to the former COS, but said nothing was done. He said when he returned from military duty in Iraq, the former Chief, Medicine Service told him he had been absent without leave. Finally, an employee, not a physician, told us the former Chief, Medicine Service denied her requests for military leave. The former Chief, Medicine Service said he did not deny this employee military leave, but a subordinate physician did because that physician believed

she had not presented the proper paperwork. The Human Resources Service staff eventually resolved the two employees' military leave issues in the employees' favor. The employee also complained of the former Chief, Medicine Service's "bad-mouthing" her and making accusatory statements. She said she took her complaints to the former COS, but nothing was done.

These and other employees characterized the former Chief, Medicine Service as volatile, egotistic, disrespectful, and unable to effectively communicate, and at least two of them said they left the BPVAMC, in part, due to the former Chief, Medicine Service's treatment of them and the former COS's ineffectiveness in dealing with it. The former Chief, Medicine Service said he was not surprised that some staff considered him to be disrespectful. He further acknowledged that he had often been criticized for his inability to listen, and that was true early in his tenure at the BPVAMC. He told us that, in an attempt to improve, he took leadership classes during the summer of 2002. Finally, the former Chief, Medicine Service noted that he was shocked when, in a meeting the week before his effective on-duty date, a service chief told him he would not work cooperatively with the former Chief, Medicine Service.

The former COS told us he did attempt to resolve employee complaints about the former Chief, Medicine Service. Beginning in June 2002, or earlier, the former COS initiated regular meetings with the former Chief, Medicine Service, often on a weekly basis, to discuss VA regulations and policies, to monitor the former Chief, Medicine Service to ensure he was following them, and to discuss the former Chief, Medicine Service's interpersonal relations with the staff. The former COS said the former Chief, Medicine Service's response to the meetings was sometimes positive, that he would nod his head and commit to being more disciplined and compliant. In an August 2002 memorandum to the former Chief, Medicine Service, the former COS referenced the weekly meetings and reiterated to the former Chief, Medicine Service that discrimination and inappropriate behavior would not be tolerated and, though he had not seen any evidence to the contrary since May, he warned the former Chief, Medicine Service that he must be fair and even-handed in dealing with all staff.

In January 2003, a year into the former Chief, Medicine Service's employment and following the receipt of additional complaints, the former COS warned the former Chief, Medicine Service that over the previous months his intimidating and threatening conduct towards staff members and his inability to listen were creating a dysfunctional environment. He instructed the former Chief, Medicine Service to take immediate actions to radically modify his approach to dealing with people, to be free of intimidation, threats, and veiled threats. The former COS told us he believed he had done everything he could to try to reform the former Chief, Medicine Service, including training him and referring him to advisors in the human resources, fiscal, and other administrative services, and to the Office of Regional Counsel. According to the current BPVAMC Director, when he arrived on-station in mid-August 2003, the former COS requested to

reassign the former Chief, Medicine Service out of that position. Effective September 1, 2003, the former Chief, Medicine Service was reassigned, but retained his position as Chief of Cardiology Service and Director of Cardio-Vascular Research. The Director told us he believed the former COS did try to give the former Chief, Medicine Service guidance, but that the former Chief, Medicine Service ignored him.

In January 2004, an administrative board appointed by the VISN 8 Director reviewed the alleged pattern of harassment and hostile work environment, and assessed actions taken to address identified problems. The board reported that its interviews with clinical staff confirmed allegations that the former Chief, Medicine Service made threatening and disparaging comments, but did not confirm similar allegations against the former COS. The board did report that the clinical staff voiced feelings of distrust toward the former COS. Among other recommendations, the board recommended that medical staff leadership be stabilized by minimizing the rotation of service chiefs; that an independent consultant with expertise in medical staff leadership development be obtained; and that actions be taken to improve communications, including widely distributing minutes of the Medical Staff Executive Board meetings, requiring all clinical services to hold regular service meetings, and ensuring appropriate representation of medical staff leaders on all key BPVAMC committees.

We concluded that the former Chief, Medicine Service created a hostile work environment, primarily regarding some BPVAMC physician staff. We further concluded that the former COS attempted to address and resolve the resulting management and interpersonal conflicts, but, as evidenced by continuing complaints, his attempts were not successful. As the former Chief, Medicine Service is no longer a VA employee, we are making no recommendations regarding his improper behavior. Our findings regarding the former COS are being provided to the VISN 6 Director for whatever action he deems appropriate.

The Former Chief, Medicine Service Misused Funds Donated to the VA-Affiliated Research Corporation. The Standards of Ethical Conduct for Employees of the Executive Branch prohibit employees from using their public office for their personal gain (5 CFR §2635.702). VA policy requires VA employees involved in the affairs of affiliated research corporations to ensure the corporation furthers the interest of the Department and its research and education programs (VHA Handbook 1200.17, paragraph 2).

In May 2002, the Pfizer, Inc. pharmaceutical company provided a \$10,000 educational grant to the former Chief, Medicine Service for a “mini-medical school”, as part of the company’s *Discovering Medical Science*TM program. Pfizer’s grant letter described the program as being focused on science and education, or other content that conferred a health benefit on the community. The grant letter further specified that the funds were to be used solely to support that program. The funds were deposited with The Bay Pines Foundation, Inc., which is the nonprofit research corporation affiliated with the

BPVAMC. In an August 2002 written explanation of the purpose of the grant, the former Chief, Medicine Service stated that it was “to be used to provide honoraria, supplies and materials to establish informational programs for the citizens of St. Petersburg to learn about the Bay Pines VA Medical Center through its medical physicians.” He stated that he planned for physicians to present health lectures in St. Petersburg that were of wide interest to the local community.

However, between September 2002 and November 2003, the former Chief, Medicine Service spent virtually all of the grant funds on unrelated, primarily personal, expenses. For example, in September 2002, \$1,696 was paid to the University of South Florida on behalf of a BPVAMC physician for his tuition and late payment fee. Additionally, the physician received \$184 to purchase textbooks. In April 2003, the former Chief, Medicine Service was paid \$2,226 and another employee was paid \$1,754 as reimbursement for travel expenses they incurred at a cardiovascular disease and sleep disorder symposia. Other payments made from the Pfizer grant included \$554 for the former Chief, Medicine Service’s subscriptions to professional journals; \$549 to pay his membership in the American Heart Association and \$510 to pay his annual dues to the American College of Cardiology; \$210 for the renewal of his Drug Enforcement Administration controlled-substances registration; and \$305 for business cards. Ten percent of the grant, or \$1,000, was retained by the Foundation for administrative expenses. As of November 2003, only \$95 remained of the \$10,000 grant. Of the \$8,905 the former Chief, Medicine Service spent, we identified no expenditures that were in support of the “mini-medical school” concept to confer a “health benefit on the community.”

The former Chief, Medicine Service told us he intended to use the grant to pay for the delivery of a series of lectures to the community on biodefense. He said he and two other VA physicians, including the one for whom a tuition payment was made, were to present the lectures. He told us the grant was unrestricted, meaning it could be used to pay for the use of the lecture hall, related travel, the lecturers’ honoraria, and other expenses related to the program. He said he invested considerable time into planning the program, and that the grant money spent on his behalf constituted his honorarium. Further, he said the tuition payment made on behalf of the other physician was, in effect, that person’s honorarium. The former Chief, Medicine Service also noted that he had spent his personal funds to pay for physicians to travel to the BPVAMC for job interviews, and he considered some of the grant money he used to be reimbursement of those expenses. While he acknowledged that a third party examining the use of the grant funds would not see that they were for honoraria, he said he was not attempting to deceive anyone. The former Chief, Medicine Service told us that the former COS stopped the program before any lectures were given. The former COS denied doing this.

Two Foundation employees, who are also BPVAMC employees, approved the use of the funds, and signed the checks, for the expenditures described above. According to one of

the employees, she was aware the Pfizer grant was meant to support a “mini-medical school”, and questioned to herself some of the expenditures. She said she wrote checks for payments of some expenditures either because the other employee, her supervisor, had already approved them, or because she believed her supervisor would direct her to process the payments even if she did question them. Regarding other expenditures, such as the controlled-substances registration and the American College of Cardiology dues, the employee told us she processed payments because it was the practice at the Foundation to pay for those types of expenses. The supervisor told us she approved the use of the funds because she considered the expenditures to be in support of research and the former Chief, Medicine Service had said the grant was to help him start his research program at the BPVAMC.

The former COS was also a member of the Foundation board of directors, responsible for managing and operating the corporation. He told us he knew about the plans for the “mini-medical school” program and that \$10,000 was available to the Foundation to support it, but said he was not aware that the funds had been used for other purposes. Further, he said he did not recall the Foundation board of directors discussing the funds at any meetings he attended. However, an employee told us that she learned in the spring of 2003 that the funds were being used for other purposes and advised the former COS to contact the Foundation.

We concluded that the former Chief, Medicine Service used his public office for his personal gain, and the personal gain of other employees, by spending Pfizer grant funds for primarily personal expenses when they were donated specifically to support a “mini-medical school” program. Since the former Chief, Medicine Service never gave any lectures in support of the program, he was not entitled to an honorarium. We also concluded that two Foundation employees, who were also BPVAMC employees, did not ensure the Foundation furthered the interests of the Department and its research and education programs, as required, and did not comply with the terms of the grant letter. Finally, we concluded that the former COS did not adequately supervise the former Chief, Medicine Service’s spending of the grant funds.

Outpatient Satellite Clinic Scheduling and Waiting List

Managers at the Ft. Myers Satellite Outpatient Clinic (SOC) managers inappropriately canceled the audiology appointments of about 1,000 nonservice-connected veterans in order to schedule service-connected veterans, substantially understated the audiology appointment waiting list by manipulating the desired dates when scheduling appointments, and failed to see some service-connected veterans within 30 days. These actions resulted in significant underreporting of the number of veterans waiting for audiology services and potentially denied these services to veterans who were entitled to them.

Managers at the Ft. Myers SOC Canceled Audiology Appointments for Nonservice-Connected Veterans. Ft. Myers SOC managers inappropriately cancelled the audiology appointments of nonservice-connected veterans in order to schedule appointments for service-connected veterans. In October 2002, the Secretary of Veterans Affairs issued a policy stating that veterans who are 50 percent or greater service-connected or who require care for service-connected disabilities must receive care within 30 days either at a VA facility, by fee-basis, or by sharing agreement at VA expense. The policy states, "Service-connection, in and of itself, does not justify cancellation of a current appointment for another veteran as a mechanism for accommodating priority scheduling for the service-connected veteran."

We interviewed managers at the BPVAMC and Ft. Myers SOC. We found that in November 2002, BPVAMC and SOC management held a videoteleconference to discuss the waiting list for audiology appointments. At this teleconference, the BPVAMC AD stated that SOC audiology staff needed to differentiate between veterans who were eligible for audiology services and veterans who were entitled to these services. According to participants at this conference, a decision was made to cancel the appointments of nonservice-connected veterans in order to accommodate service-connected veterans.

From January 2003 until May 2003, SOC schedulers canceled about 2,000 audiology appointments for about 1,000 nonservice-connected veterans. In May 2003, at the request of the SOC audiologist, VHA Audiology and Speech Pathology Service clarified that all veterans were entitled to evaluation of hearing loss for medical need, regardless of what treatment services the veterans were eligible for. In July 2003, SOC schedulers began adding names of veterans whose audiology appointments had been canceled to the electronic wait list (EWL). Veterans were added to the EWL when the SOC could not schedule them within 180 days.

We identified 25 veterans who had their audiology appointments canceled between October 1, 2002, and June 30, 2003, and had not received care or had their appointments rescheduled. SOC staff agreed that these 25 veterans had been erroneously left off the EWL and therefore would not receive the care they were entitled to. During the week of May 3, 2004, SOC managers began contacting the 25 veterans to determine if they still wanted appointments. As of May 6, 2004, the SOC had contacted 16 of the 25 veterans and were continuing efforts to contact the remaining 9. Of the 16 veterans contacted, 11 received audiology appointments. The remaining five veterans said that they no longer wanted appointments.

In April 2003, the VISN 8 Director redirected \$5 million from VISN 8 VERA reserves, to reduce or eliminate the wait list in VISN 8 facilities. Bay Pines received \$1 million of the dollars distributed. As a result of the SOC's inappropriate cancellation of more than 2,000 appointments for nonservice-connected veterans and the corresponding perception

that the SOC did not have a significant audiology wait list, the SOC did not receive a share of these funds.

Ft. Myers SOC Managers Understated the Waiting List. SOC managers understated the number of veterans waiting for audiology appointments. This understatement occurred because SOC managers directed clinic schedulers to manipulate the scheduling module in the VistA system by entering all appointments as “other than next available” and then inserting desired dates that allowed the SOC to establish appointments for veterans within the 180-day requirement.

The VistA scheduling package requires schedulers to enter appointments as either “next available” or “other than next available”. The “next available” option should be used when the veteran needs an appointment as soon as possible. Typically, this option is used for new patients, or when the provider determines the patient needs care as soon as possible. The “other than next available” option should be used to establish an appointment for a specific date. Typically, this option is used when the provider wants the veteran to return for a follow-up appointment (for example, an appointment in 6 months).

We interviewed the Supervisory Medical Administrative Specialist and two audiology clinic schedulers to determine why schedulers used the “other than next available” option when scheduling appointments. They told us that 2 to 3 years ago, the Chief and Assistant Chief of the BPVAMC Health Benefits Administration Service directed schedulers not to use the “next available appointment” option. Instead, schedulers were directed to first go into the scheduling module to find the next available appointment date but not to enter the veteran’s appointment. Next, the schedulers were directed to exit the module and then restart the appointment search entering a specific date close to the next available appointment day. The scheduling module would then pick up the entered day as the desired date and the calculated wait time would be measured from the desired date to the actual appointment date. This manipulation of the scheduling system substantially reduces the reported waiting time and, thereby, eliminates the need to include the veteran on the waiting list.

As the following examples illustrate, the manipulation of the scheduling package module significantly underreported the time veterans waited for audiology appointments:

- A veteran’s provider requested an audiology appointment on December 27, 2001. On March 15, 2004 (809 days later), the veteran was given an appointment for April 9, 2004. The scheduler entered the appointment as an “other than next available” with a desired date of April 5, 2004. The SOC reported that the veteran waited 4 days for his appointment when he actually waited 834 days.
- A veteran’s provider requested an audiology appointment on February 2, 2002. On January 27, 2004 (575 days later), the veteran was given an appointment for April 1,

2004. This appointment was canceled on the same day it was entered because of a conflicting appointment with another clinic and was rescheduled for April 5, 2004. The scheduler entered the second appointment as an “other than next available” with a desired date of April 1, 2004 (the date of the canceled appointment). The SOC reported that the veteran waited 4 days for his appointment. He actually waited 644 days.

Although we were not able to quantify the extent of the audiology waiting list understatement, we believe it was significant. In October 2002, the SOC reported fewer than 150 veterans waiting for appointments for more than 180 days. However, once the schedulers began adding the nonservice-connected veterans to the EWL in July 2003, the audiology waiting list increased to more than 1,000 veterans.

Service-Connected Veterans Did Not Receive Audiology Appointments Within 30 Days.

Service-connected veterans at the SOC did not receive audiology appointments within 30 days in accordance with VA policy. VHA managers monitor each facility’s compliance with this policy by running a report that identifies veterans who meet the priority criteria and who are not scheduled within 30 days of their desired appointment dates. The monitor uses the difference in days between the desired and actual appointment dates. To ensure the integrity of the monitor and that service-connected veterans receive appointments within 30 days, schedulers must classify the appointment correctly as either “next available” or “other than next available.”

Fifteen of the 19 appointments we reviewed were for veterans who were either more than 50 percent service-connected or service-connected for hearing loss. The schedulers entered all 15 appointments as “other than next available” even though these appointments were initial appointments and should have been entered as “next available.” As a result, the SOC reported that all 15 service-connected veterans received their appointments within 30 days. We found that 11 of the 15 actually waited anywhere from 32 to 58 days, with an average of 40 days, for their appointments.

When we reported the problem of canceled audiology appointments to BPVAMC management, they obtained additional fee-basis funding to provide audiology care to veterans who still wanted it. As of May 10, 2004, all veterans who were waiting for appointments and could not be seen at BPVAMC or the SOC were mailed letters advising them that VA would arrange to have them treated by private sector providers at VA expense.

The Facility Bulk Oxygen System Was Not Properly Managed

Non-compliance with Federal requirements for maintenance of medical gas systems, and non-compliance with VA contract requirements, contributed to a loss-of-oxygen incident at the medical center. A report prepared by the VISN 8 Safety Coordinator showed that during an oxygen refill on January 17, 2004, a contractor employee left a fill valve open

and oxygen began leaking from the main tank. On January 21, 2004, a low-level oxygen alarm sounded at the medical center switchboard. The telephone operator called the medical center energy center to report the situation, however, Facility Service Support personnel did not respond to the incident.

On January 22, 2004, a loud leaking sound was heard and a noticeable vapor trail was seen, and the vendor was called. The vendor responded within an hour and closed the open fill valve. During the period the fill valve was left open, oxygen was supplied from the reserve tank. The reserve tank has a capacity of 300 gallons.

Our review of the BPVAMC Safety Committee meeting minutes found that medical center staff reported that excessive ice build-up around the main tank also contributed to a decrease in oxygen pressure, not allowing the system to function properly. Our interviews with BPVAMC employees found that alarms did not sound when the supply switched to the reserve tank because the reserve tank was not connected to the main oxygen alarm panels, and neither the main nor reserve tank were connected to a low system pressure alarm.

Additionally, the oxygen alarms were not properly labeled and the alarm at the switchboard showed low pressure, when in fact there was a low oxygen level condition. Medical center employees did not know at what low-level or low-pressure readings the alarms should sound.

BPVAMC was not in compliance with pertinent Federal and Joint Commission on Accreditation of Healthcare Organization (JCAHO) requirements.¹¹ NFPA-50 requires annual inspections of bulk oxygen systems by a qualified representative of the owner of the equipment. NFPA-99 requires a master alarm system consisting of two alarm panels that monitor medical gas and vacuum piping systems and a reserve tank that stores at least 1 day supply of oxygen. The system must also have an alarm that announces when:

- Oxygen levels in the main and reserve tanks are low (an average day's supply).
- Pressure in the main and reserve tanks is low.
- The reserve tank is in use.

NFPA-99 also requires that facilities periodically test alarms, label alarm panels properly, and maintain permanent records of testing.

On April 5, 2004, the VHA issued a Patient Safety Alert (PSA) in response to loss-of-oxygen incidents that occurred at two other VA medical centers. The PSA required that

¹¹ National Fire Protection Association (NFPA) 99 Code, 2002 Edition requirements; NFPA-50, Standard for Bulk Oxygen Systems at Consumer Sites, 2001 Edition requirements; Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Management of the Environment of Care (EOC) standards. These standards require that hospitals maintain, test, and inspect medical gas and vacuum systems.

VA medical centers comply with the NFPA-99 requirements (most of the criteria described above was cited in the PSA), by April 30, 2004. Additionally, while not required by NFPA-99, the PSA required that medical centers monitor both required oxygen alarm panels 24 hours a day.

During our inspection of BPVAMC's bulk oxygen utility system from May 10-13, 2004, we interviewed employees, inspected the bulk oxygen area and alarm panel areas, and reviewed medical center policies and the April 2, 2004, VISN 8 incident report.

The BPVAMC bulk oxygen system was located outside the warehouse area of Building 100, surrounded by a fence and vehicle barrier poles. The system consisted of a main tank holding 3,000 gallons of liquid oxygen, and a reserve tank with a capacity of 300 gallons. The reserve tank capacity was at the minimum safe threshold, and a larger capacity tank should be considered.

The BPVAMC also did not comply with the requirements of the national contract awarded by VA's National Acquisition Center (NAC). The contract provides guidance to the Contracting Officer Technical Representative (COTR) for local administration of the bulk oxygen contract, and requires that the COTR establish a MOU with the vendor, outlining the COTR's responsibilities, bulk oxygen ordering procedures, and specific details for delivery, within 15 days after the contract award. Medical centers were also required to provide the NAC a copy of the MOU. The NAC contract also suggests that the COTR consider establishing alternate ordering and delivery methods with the vendor to improve administrative control, such as pre-scheduled deliveries, calling for tank level readings, or installing telemetry units to monitor oxygen levels.

We concluded that the loss-of-oxygen incident was poorly managed and that BPVAMC was not in compliance with the applicable codes. In addition, the bulk oxygen contract was not properly managed.

Conclusion

The details of the issues presented above led us to the conclusion that senior leadership has not been effective in managing the clinical and administrative issues we reviewed.

Recommended Improvement Action(s) 1. The Deputy Under Secretary for Operations and Management needs to ensure that the VISN formulates, reviews, and implements action plans to improve the leadership of the BPVAMC and ensure a "Culture of Safety" at the BPVAMC.

Recommended Improvement Action(s) 2. The Acting Under Secretary for Health in conjunction with the Deputy Under Secretary for Operations and Management needs to develop and implement productivity standards for physicians as directed by Public Law 107-135.

Recommended Improvement Action(s) 3. The Director VISN 8, in conjunction with the Medical Center Director needs to:

- a. Ensure that BPVAMC resumes a formal AEB, or similar administrative committee structure, that documents senior management discussions, decisions, action plans, and solutions.
- b. Request that The Bay Pines Foundation, Inc. bill the former Chief of Medicine \$8,905 to recoup funds donated for a “mini-medical school” program, which he improperly spent.
- c. Take appropriate administrative action against the two employees who approved the use of grant funds from Pfizer, Inc. for not ensuring the Bay Pines Foundation, Inc. furthered the interests of the Department and its research and education programs, and for not complying with the terms of the grant letter.
- d. Require Ft. Myers SOC schedulers to enter initial audiology appointment requests as “next available” appointments and return visits as “other than next available appointments.”
- e. Promptly resolve the bulk oxygen system deficiencies and brings the system into compliance with NFPA-99, NFPA-50 requirements, and the VHA PSA.
- f. Establish a MOU with the local oxygen vendor that includes all the requirements of the NAC contract.
- g. Establish procedures to monitor oxygen level readings and conduct routine site inspections.
- h. Provide and document training to employees responsible for maintenance of the facility bulk oxygen system.
- i. Obtain annual inspections of medical gas systems conducted by a qualified representative of the equipment owner.
- j. Install a larger capacity reserve tank.

Recommended Improvement Action(s) 4. The Deputy Under Secretary for Operations and Management needs to take appropriate administrative action against the former COS for not adequately supervising the former Chief, Medicine Service’s spending of Pfizer, Inc. grant funds.

Acting Under Secretary for Health, Deputy Under Secretary for Operations and Management, and VISN and BPVAMC Directors' Comments:

The Acting Under Secretary for Health, Deputy Under Secretary for Operations and Management, and VISN and BPVAMC Directors concurred with the recommendations and provided acceptable implementation plans. Details of their responses are shown in Appendix G, pages 133-146.

Office of Inspector General Comments:

The Acting Under Secretary for Health, Deputy Under Secretary for Operations and Management, and VISN and BPVAMC Directors comments met the intent of the recommendations. We will continue to follow-up on all planned actions until the issues are resolved.

Issue 2: Care in Selected Clinical Services

Findings

Elective Surgery Backlogs Existed in Several Surgical Specialties

In our Interim Report, we noted that BPVAMC managers did not properly supervise SPD assets, which resulted in the cancellation of 81 surgeries in November 2003 and February 2004.¹² Operating Room case carts were often missing supplies or instruments, or the instruments were not properly sterilized. Urgent and emergent surgical cases were completed as scheduled, and were not affected by the OR closures. Canceled elective surgeries were all rescheduled and completed with the exception of two patients who declined rescheduling, one patient who opted for medical intervention, and two patients who stated they would contact their providers with a date that would best suit their calendar. One patient failed to appear on the date of his rescheduled procedure.

After the February 2004 Operating Room closure, Surgery Service resumed operative procedures 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 Haley VAMC SPD Chief to the BPVAMC on March 1, 2004, to evaluate and address supply and sterilization problems in the service. The OR nurse manager told us that as of mid-May 2004, conditions had significantly improved, and the OR had not experienced additional incidents in which supplies or equipment were missing or not sterilized. The OR nurse manager reported that they continue to run five OR suites, but have increased their workload to 12 to 15 surgeries per day. They anticipate reopening the sixth OR suite in September 2004.

We found that as of May 18, 2004, five Surgery Service specialties had elective surgeries scheduled beyond 30 days. These were orthopedics (69 cases), urology (43 cases), podiatry (19 cases), ophthalmology (7 cases), and plastic surgery (3 cases). Medical center managers told us that these delays were attributable in part to the SPD problems discussed above. The Acting Chief of Surgery had taken several actions to decrease the backlog, including working with SPD managers to ensure availability of instrumentation to meet the increasing surgical demand, fee-basing patients out to the community when appropriate, and recruiting sufficient staff to open all of the surgical suites.

The Urology Service staff consists of four full-time surgeons. However, the practices of some of these surgeons are limited. In our opinion, the staffing level at the time of our

¹² An additional 31 surgical cancellations from October 1, 2003, through March 15, 2004 were reported to the OIG. We reviewed the medical records for these patients and found no correlation to SPD issues (e.g., missing equipment or sterilization issues).

review was inadequate to meet the urological surgical needs of the veteran population covered by the BPVAMC.

Recommended Improvement Action(s) 5. The VISN Director needs to ensure that the BPVAMC Director completes a comprehensive review of the Surgery Service, including surgical subspecialties, to ensure timely delivery of surgical care. Actions should be taken to notify our office when surgical timeliness deficiencies have been corrected, staffing adjustments have been made, and full OR capacity has been restored.

VISN and BPVAMC Directors' Comments:

The VISN and BPVAMC Directors concurred with the recommendation and provided acceptable implementation plans. Details of the response are shown in Appendix G pages 146-148.

Office of Inspector General Comments:

The VISN and BPVAMC Directors comments and implementation plans met the intent of the recommendation. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Radiology Service Did Not Provide Timely and Adequate Support

The BPVAMC Radiology Service offers general x-rays, Computerized Tomography (CT) scanning, Magnetic Resonance Imaging (MRI), ultrasonography, angiography, interventional radiological procedures, and screening mammography. In FY 2003, Radiology Service completed more than 80,000 examinations, and based on 1st quarter FY 2004 data is projected to complete more than 100,000 examinations by the end of the fiscal year. The service has an approved ceiling of 46.3 FTE of which 6.8 FTE are radiologists. As of January 14, 2004, there were 3.5 FTE vacancies, including 1.5 FTE radiologist positions and 2 FTE clerk positions.

- Waiting Times for Routine Examinations Exceeded 30 Days

Waiting times to schedule and complete some routine radiological examinations often exceeded the facility's 30-day standard:

	Next Available Appointment (in days)			
	March 2001	March 2002	March 2003	March 3, 2004
CT	13	40	47	28
MRI	80	88	67	89
Ultrasound	117	17	12	36

BPVAMC Radiology Service managers have taken several remedial actions to improve waiting times for scheduled procedures, including the addition of evening and Saturday hours, staff recruitment, and purchasing new equipment. Despite these efforts, waiting times for routine examinations often continued to extend beyond 30 days.

- Radiology Waiting Times for Image Interpretation Were Unacceptable

Radiology Service had extensive backlogs for film and image interpretations. Once radiological examinations are completed, a radiologist must review the films or images produced and provide a diagnostic interpretation. The time frame within which a radiological study should be interpreted depends on the type of examination and the urgency of the request. According to facility guidelines, “stat” (emergency) requests require the examination to be performed and its interpretation completed within 1 hour. “Urgent” requests require the examination and interpretation within 2 hours. “Routine” requests require the examination within 30 days and image interpretation within 4 days of examination completion.

Image interpretation backlogs have been a long-standing problem at the BPVAMC. A February 26, 2003, memorandum from the Chief, Clinical Diagnostic Support Service (CDSS) to the Chief of Staff reported that, “As of February 26th, the CDSS Imaging section has reduced the backlog of unread exams from 3000+ to 900 over the past 2 weeks,” and that “...it is our hope that by mid March [2003] the section will be able to perform a 48 hour or less turn around time for all imaging exams.” However, as of February 24, 2004, there remained 1,099 unread examinations, with some routine MRI examinations dating back to December 9, 2003.

The Acting Chief, Radiology Service, reported that delays in image interpretation were the result of management’s failure to listen to his needs and their denial of his repeated requests for resources. In May 2001, Radiology Service phased in various components of the Picture Archive Communication System (PACS) program, which allows radiologists and other providers to view digital images on computer workstations, thus obviating the need for hard copy films. By July 2003, all radiographic images (with the exception of mammograms) were available on and interpreted from PACS. This enhanced technology resulted in an increase in the number images needing interpretation.

Timely interpretations are critical to quality patient care. Delayed interpretations of radiological examinations can result in delayed diagnosis and, for some patients, a delay in instituting potentially life-saving treatment.

One case in which a delay in interpretation resulted in a poor outcome was identified, as follows:

On June 17, 2003, a veteran was seen at a CBOC for a complaint of chronic back pain and numbness that extended down his right leg. His physical exam did not localize to a specific anatomical area. A diagnosis of low back pain was made with plans to obtain spine films at a future date if the pain continued. On October 31, 2003, the veteran called a BPVAMC health care provider to indicate that he was experiencing abdominal pain that felt like a “rope tightening.” The veteran was offered and accepted an appointment with a primary care provider on November 20, 2003. At this visit, the patient offered the same complaints of abdominal pain and indicated that he had decreased sensation from his “mid-abdomen down.” Upon examination he was found to have a decreased sensation to a sharp pin below the T8 thoracic spine level. The provider assessed the patient to have thoracic spine disease and ordered an MRI. The MRI was performed on November 21, 2003, but not interpreted until December 16, 2003, at which time it was recognized that this patient had a T3 thoracic spinal cord tumor. The patient was seen in clinic on December 17, 2003, and informed of the results of his MRI. During this visit he indicated that his symptoms had progressed. The patient was then referred to a civilian neurosurgeon and had spinal surgery on January 9, 2004. Postoperatively, he has significant paralysis in both lower extremities and is incontinent.¹³

- Stat and Urgent Examinations Were Inappropriately Ordered

Physicians often inappropriately classified radiology requests as “stat” or “urgent” because they believed that was the only way to obtain timely service for their patients. From October 1, 2003, through March 22, 2004, 12,771 of the 45,146 radiology examinations (28 percent) were requested on either a “stat” or “urgent” basis. We reviewed radiological examinations with a “stat” or “urgent” designation, and found that 1,357 (11 percent) of the examinations were ordered by the requesting provider for a future date, a practice that is inconsistent with the stat or urgent designation. We reviewed the remaining 11,414 “stat” or “urgent” examinations and found that 7,983 (70 percent) were not interpreted within Radiology Service’s time requirements.

- Mammograms Were Not Interpreted in a Timely Manner

Radiologists did not interpret mammogram films in a timely manner. From October 1 to December 31, 2003, 431 mammograms were completed, but only 22 (5 percent) of those films were interpreted within 4 days, the medical center standard. Forty-one films (10

¹³ On April 16, 2004, this patient was notified of his rights for compensation under the law as the reading of his MRI was delayed.

percent) went uninterpreted for more than 30 days. We reviewed all of these patients' medical records in order to assess whether the 30 or more day delay in mammogram interpretation had an adverse clinical impact. We did not identify any adverse effects from these delays.

On January 30, 2004, the Chief of Staff detailed a fee-basis radiologist to interpret mammograms. We found that as of June 8, 2004, mammograms were being interpreted and reported within established standards.

- Managers Did Not Adequately Monitor Radiology Service Productivity

The Acting Chief, Radiology Service, stated that he did not monitor radiologist productivity because: 1) he was not required to, and; 2) if there was a requirement, the information available did not appropriately account for the radiologists' actual workload.

On March 7, 2004, the director of VHA's radiology product line conducted an external review of the BPVAMC Radiology Service. He later informed OIG that there are no productivity standards for VA radiologists. He advocated the use of relative value units (RVU)¹⁴ to assess radiologist productivity. He stated that 5,000 annual RVUs would be the norm for full-time VA radiologists who have collateral administrative, educational, or research duties.

Since none of the BPVAMC radiologists had approved education or research duties, and administration functions were primarily assigned to the Acting Chief, Radiology Service, we performed a workload analysis using 6,000 annual RVUs as a standard of productivity that might be reasonably expected from BPVAMC radiologists.

¹⁴ RVUs are weighted units of measurement that allow for a workload comparison between different complexities and case mixes.

The tables below show the RVUs completed by the Bay Pines radiologists.

FY 2003 RVU Analysis			
Full and Part-Time Radiologists	Number of RVUs Completed	Number of RVUs Expected *	Number of RVUs Over/Under 6,000 RVU Standard
1 (part-time)	7,170.87	4,630.09	2,540.78
2	4,670.20	4,571.15	99.05
3	5,988.75	6,000.00	(11.25)
4	5,548.75	6,000.00	(451.25)
5	4,280.21	6,000.00	(1,719.79)
6	3,894.85	6,000.00	(2,105.15)
Fee Basis Physicians			
A	5,015.24	2,987.67	2,027.57
B	2,578.43	1,604.82	973.61
C	1,503.97	1,239.84	264.13
D	1,927.05	1,722.00	205.05
E	190.90	172.20	18.70
F	297.74	292.74	5.00
G	1,123.47	1,483.79	(360.32)
* Based on a standard of 6,000 completed RVUs per year and pro-rated based on number of hours paid to the radiologist.			

FY 2004 (as of March 22) RVU Analysis			
Full and Part-Time Radiologists	Number RVUs Completed	Number of RVUs Expected *	Number of RVUs Over / (Under)
1(part-time)	3,204.05	1,667.47	1,536.58
3	3,080.67	2,874.94	205.73
4	2,764.72	2,874.94	(110.22)
7	488.47	620.99	(132.52)
6	2,292.17	2,874.94	(582.77)
5	2,026.78	2,874.94	(848.16)
Fee Basis Physicians			
A	2,151.28	1,356.97	794.31
D	1,236.71	891.23	345.48
E	976.28	738.28	238.00
H	374.65	298.99	75.66
C	1,536.02	1,620.89	(84.87)
G	1,091.00	1,333.97	(242.97)
* Based on a standard of 6,000 completed RVUs per year and pro-rated based on number of hours paid to the radiologist.			

The Acting Chief, Radiology Service, could not explain the RVU variances among his staff radiologists and whether those variances were acceptable.

- Medical Center Leadership and the Radiology Service

We found that BPVAMC senior management knew or should have known of this backlog over a substantial period of time. For example, a July 11, 2001, memorandum to the BPVAMC Resource Committee that was endorsed by the COS, reported that additional staff were needed to reduce the excessive waiting time for CT, MRI, and ultrasound appointments. During the exit conference for the January 2003 VAOIG CAP review of the BPVAMC, we informed the Acting Medical Center Director that the 1.5 to 2.5 month delay in the interpretation of radiology studies was not acceptable. The October 17, 2003, memorandum to the Medical Center Director alleges that, “As a result of the failure of the COS to make timely appointments of sufficient radiologists, radiographic services for veterans have suffered in a grave and unacceptable manner. Radiographic studies have been unread and unreported in the electronic data system for up to 8 weeks after completion.” As of January 12, 2004, there was a backlog of 300 unread MRI scans, 350 CT scans, and 450 plain film x-rays.

Effective actions to eliminate the backlog did not take place until well into 2004. On March 7, 2004, facility managers reported that they had contracted with a local radiology group to interpret BPVAMC x-rays; contracted with a private radiology group in Ft. Myers, Florida to perform and interpret x-rays; contracted with a company to provide remote x-ray interpretations; and increased the number of radiologists available to interpret x-rays at the BPVAMC.

- External Review of the Radiology Service

An external review of the Radiology Service dated March 7, 2004, identified similar findings to our results. VHA’s National Radiology Program director evaluated the BPVAMC Radiology Service and made multiple recommendations designed to reduce scheduling delays, eliminate interpretation backlogs, improve radiologist morale, and improve oversight of procedures.

In addition, this review noted that several radiologists had moonlighting arrangements that might interfere with their VAMC responsibilities at a time when interpretations were so delinquent. The March 7, 2004, report recommendations also included a recommendation to temporarily increase capacity to work down the backlog, and to ensure that all inpatient and stat examinations are interpreted the same day.

Recommended Improvement Action(s) 6. The VISN Director, in conjunction with the Medical Center Director needs to:

- a. Ensure that radiographic examinations are scheduled and images are interpreted within required time frames.
- b. Ensure that providers properly designate the urgency of radiological study requests.
- c. Take actions to ensure that Radiology Service develops workload and performance standards so that assets may be appropriately managed.
- d. Ensure that Radiology Service quality improvement plans encompass the interpretation of x-rays performed under contract.

VISN Director and BPVAMC Director’s Comments:

The VISN and BPVAMC Directors concurred with the recommendation and provided acceptable implementation plans. Details of this response are shown in Appendix G pages 149-150.

Office of Inspector General Comments:

The VISN and BPVAMC Directors comments and implementation plans met the intent of the recommendation. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Clinical Leadership Did Not Ensure Timely Neurosurgery Access

We found that routine neurosurgery consultations could not be obtained in an expeditious or timely manner. The BPVAMC does not offer neurosurgery services, and therefore, must utilize other VISN facilities or private providers. This problem has been well documented by internal memoranda as far back as 1998. We found that patients referred for non-emergent neurosurgery consultations frequently waited more than 30 days for outpatient clinic neurosurgery appointments and in some cases more than 9 months.

The referral and evaluation process was cumbersome to the point of frequently being ineffective. For example, there were no functioning procedures among VISN 8 facilities regarding referral or evaluation of neurosurgery patients. Between January and December 2003, 489 BPVAMC outpatients were referred to Tampa, Miami, or Gainesville, FL VAMCs for neurosurgical evaluations. As of February 9, 2004, 189 of these consultations had been completed, 96 were still pending, and the remaining consultations were not completed for a variety of reasons, including incomplete work-ups and patient “no-shows.”

The Haley VAMC is designated as the primary VHA referral center for BPVAMC patients requiring neurosurgery services. As of March 22, 2004, 34 patients referred to the Haley VAMC since January 1, 2004, were still awaiting appointments. In one case, on January 14, 2004, providers referred a patient to the Haley VAMC Neurosurgery Service requesting a consultation within one week. The Haley neurosurgeon reviewed the patient's medical records on February 12, 2004. As of May 28, 2004, the patient had not been examined by a neurosurgeon. Haley VAMC has 0.5 neurosurgery FTE, which is divided among three neurosurgeons. The Haley VAMC Chief of Surgery stated that Haley VAMC does not have the excess capacity to manage BPVAMC's referrals. There is a disconnect between the Haley VAMC's designation as BPVAMC's referral center and its ability to manage the resultant workload. BPVAMC staff also reported that the facility did not have any contracts or agreements with local neurosurgical groups. Thus, clinicians referring emergency cases reported that they often had to make multiple phone calls in an attempt to locate a neurosurgeon (VHA or private) who would accept their case. This lack of established procedures and service agreements at a minimum caused frustration and disrupted care. At worst, it put patients at increased risk. In one case, the BPVAMC on-call surgeon had to contact eight different physicians to arrange transfer of an acutely ill neurosurgical patient. The medical record reported:

“Upon dx [diagnosis] of [brain] hemorrhage, the SOD [Surgeon of the Day] (myself) evaluated the pt [patient], general surgery attending Dr. [One] was called, he recommended calling neurology, Bay Pines. Dr. [Two] was called. She stated that although neurology would be happy to admit, they would need neurosurgical backup which is not available at Bay Pines. Neurosurgery at VA Haley was called. Dr. [Three] who stated that this was not a neurosurgical patient as neurosurgery would only intervene if the bleed broke into the ventricle, therefore he would not accept the pt [patient]. At this point Dr. [Four] was contacted. He suggested calling Dr. [Five] at Haley VA to resolve the issue as Dr. [Four] was out of town. Dr. [Three] was again called first to give him the opportunity to change his mind about accepting the pt, but he refused. He did state that he would be happy to be involved as consultant if the patient was admitted to neurology at Haley. Next, the neurologist on call for Haley was called [Dr. Six]. He stated that he would be happy to admit the patient except that the patient would need an MICU [Medical Intensive Care Unit] bed and neurology at Haley does not have MICU privileges. He said that he would take care of the patient if he was admitted to TGH [Tampa General Hospital], where they do have MICU privileges. At this point, Dr. [Seven] was called. He stated that the MICU did not have any beds and there was only one bed in the SICU [Surgical Intensive Care Unit], and therefore, he recommended that the patient be admitted to TGH neurology with neurosurgery consultation. Dr. [Six] was called back for acceptance for the pt to TGH. Dr. [Six] stated that he was not on call for TGH tonight and gave the name and number of the doctor on call, Dr. [Seven]. She was called and stated that she

could not accept as she is a resident. Finally, Dr. [Eight] was called who accepted the patient and transfer was arranged.”

The VISN Chief Medical Officer told us that a VISN Health Systems Committee was chartered to develop a standardized approach to neurosurgical care across the VISN.

Recommended Improvement Action(s) 7. The VISN Director should ensure that the BPVAMC Director establishes a clear and effective referral mechanism for obtaining timely inpatient, outpatient, and emergency specialty and subspecialty service consultation for specialties not inherent to the facility.

VISN Director and BPVAMC Director’s Comments:

The VISN and BPVAMC Directors concurred with the recommendation and provided acceptable implementation plans. Details of this response are shown in Appendix G, page 151.

Office of Inspector General Comments:

The VISN and BPVAMC Directors comments and implementation plans met the intent of the recommendation. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Pulmonary Service Did Not Provide Timely and Adequate Services

Pulmonary Service at the BPVAMC has 4 physician FTE, down from 5 FTE in April 2003. Their responsibilities include intensive care unit (ICU) coverage from 8:00 AM to 4:30 PM, Monday through Friday and 4 hours on Saturday and Sunday; inpatient pulmonary consultations; invasive pulmonary procedures; outpatient pulmonary clinic; pulmonary function test supervision; the home oxygen program; the sleep study program; and clinical research. One pulmonary physician has 13 active research protocols and another physician has 3.

- Pulmonary Clinic Cancellations

Patients scheduled to be seen in the Pulmonary Clinic frequently had their appointments canceled. For example, we reviewed the Pulmonary Clinic workload for patients scheduled for new appointments and for patients requiring follow-up visits. During the week of May 10-14, 2004, 17 patients who were scheduled for Pulmonary Clinic visits had their appointments cancelled by providers in the Pulmonary Clinic. Five of these appointments had been initially scheduled in January and February 2004. Two of these 5 appointments were rescheduled for June 2004. As of the date of our visit, three of the appointments had not been rescheduled. Of the remaining 12 patients, 6 had not been rescheduled.

We reviewed the employee time and attendance (ETA) records for the four pulmonary physicians at the BPVAMC. Our review of the ETA records and the monthly schedule of the pulmonary section found that physicians took a “day off” on Fridays as compensation for working 4 hours in the ICU on Saturdays and Sundays. The physicians alternated their “day off” and each physician was off on a Friday during each month resulting in limited clinic time. VA Medical Center Policy, 516-01-05-1, May 2001, *Hours of Duty and Leave Absence*, provides for the policy, responsibility and procedures regarding hours of duty and leave/absences. Paragraph 3(b)4 of this memorandum states that full-time physicians may be granted approved absence not to exceed 24 consecutive hours for rest and relaxation when required to serve long hours in arduous professional efforts in the care and treatment of patients. This authorized absence if approved must be taken immediately (i.e., the next day, if the next day is a scheduled duty day) following the arduous duty. The scheduling of Fridays off as compensation for weekend coverage does not comply with the relief contemplated for arduous duty.

- There Were Long Delays in Diagnosing Lung Cancer

We reviewed 10 patient medical records that were referred to us to assess the length of time between the first radiological evidence of suspicious lung lesions and definitive diagnosis. In six of these cases, the time elapsed from first detection of a lesion on chest x-ray (CXR) to tissue diagnosis ranged from 49 days to 126 days (mean 82 days). In 2 of the remaining 4 cases, a clinical decision by a physician to monitor the abnormality with serial CT scans was made. In the third of the remaining 4 cases, no physician followed up on the abnormal CXR. In the fourth case, appropriate work-up was scheduled, but the patient did not keep numerous appointments for further evaluation. The clinical presentation and ensuing events for 2 of these 10 cases are detailed below:

- On August 13, 2003, the patient had a CXR that revealed a patchy density in the left upper lung region that suggested the presence of either an inflammatory process or a cancer (or both). The radiologist indicated that this CXR was, “abnormal, needs attention.” On October 23, 2003, the patient had a chest CT scan that was interpreted as showing a lung lesion consistent with malignancy. On November 25, 2003, he was seen by a pulmonologist who scheduled a chest CT scan with biopsy for December 24, 2003. However, on December 13, 2003, before that biopsy was performed, the patient presented to the medical center’s emergency room with a fever, and was admitted to the medical center whereupon a new CXR showed that the lung mass had increased to five times its previous size. On December 17, 2003, he had a chest CT with biopsy that was positive for non-small cell lung cancer. The total elapsed time from the initial suspicious CXR to a definitive diagnosis of non-small cell lung cancer was 126 days.

- On September 11, 2003, the patient had a CXR that showed increasing fibroganulomatous changes (i.e., evidence of active inflammation and scarring) that had developed since the patient's previous CXR 5 months earlier. On October 24, 2003, the patient had a chest CT scan that showed a density in his left lower lung extending to the left hilum (the base of the tracheobronchial tree). The cause of this abnormality was not known, and a lung cancer could not be excluded on the basis of the radiological tests alone. On December 31, 2003, the patient had a bronchoscopy with biopsy that revealed a small cell lung cancer. The time elapsed from the CXR showing an active and progressing process in the patient's lungs until the definitive diagnosis that small cell lung cancer was the cause of this process was 112 days.

Recommended Improvement Action(s) 8. The VISN Director should ensure that the BPVAMC Director:

- a. Clearly enunciates the priority of patient care over possible competing endeavors to ensure that veterans receive timely appropriate care.
- b. Reinforces physician staff time and attendance requirements and require each physician to certify that they are aware of VA policies on the granting of leave and days off.
- c. Develops a process to ensure timely diagnosis of suspicious lung lesions.

VISN Director and BPVAMC Director's Comments:

The VISN and BPVAMC Directors concurred with the recommendations and provided acceptable implementation plans. Details of this response are shown in Appendix G, pages 151-152.

Office of Inspector General Comments:

The VISN and BPVAMC Directors comments and implementation plans met the intent of the recommendation. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Ineffective Management of Patients Requiring Sleep Studies

As of March 2, 2004, there were 476 patients awaiting sleep studies at the BPVAMC. Two patients had been on the waiting list since August and October 2000, respectively. In order to address this backlog, the BPVAMC is currently spending approximately \$350,000 per year to purchase 500 sleep studies from a non-VA provider. VHA's April 14-15, 2004, review of the BPVAMC Pulmonary, Critical Care Medicine, and Sleep Programs recommended, "If the Bay Pines VA is going to continue to require 500 or

more sleep studies per year, then an in-house sleep laboratory should be strongly considered.”

Several BPVAMC clinicians objected to the referral process for sleep studies. Their concern was that there was insufficient Pulmonary Service input into the referral of patients for these studies. We found that BPVAMC primary care physicians directly referred patients to the BPVAMC Sleep Clinic, whereupon they would be placed on a waiting list for evaluation at a private sector sleep center. There was little or no evidence that BPVAMC primary care physicians made these Sleep Clinic referrals based on established clinical criteria or guidelines. In turn, after receiving the referral request, BPVAMC Pulmonary Clinic staff did not evaluate the referrals in order to determine a patient’s appropriateness for the requested studies.

This data show that the BPVAMC currently lacks an efficient and effective means of evaluating patient’s with possible sleep disorders.

Recommended Improvement Action(s) 9. The VISN Director should ensure that the Medical Center Director establishes practice guidelines to ensure that patients receive timely and appropriate consultation when a sleep disorder is suspected.

VISN Director and BPVAMC Director’s Comments:

The VISN and BPVAMC Directors concurred with the recommendation and provided acceptable implementation plans. Details of this response are shown in Appendix G, pages 152-153.

Office of Inspector General Comments:

The VISN and BPVAMC Directors comments and implementation plans met the intent of the recommendation. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Cardiology Service/Cardiac Catheterization

Several complainants alleged that BPVAMC managers inappropriately allowed cardiologists to perform cardiac catheterization procedures without on-site cardiovascular surgery back-up, and that the cardiac catheterization complication rate was excessive.

In September 2002, the BPVAMC received authorization from VACO to operate an interventional cardiac catheterization program, even though the facility did not have a cardiovascular surgery service. We found documentation that the BPVAMC Critical Care Committee reviewed this issue, made several recommendations to ensure that a proposed cardiac catheterization program met applicable standards, and concluded that all issues had been satisfactorily addressed. In October 2002, the facility hired an

interventional cardiologist who is credentialed and privileged to perform a broad range of interventional cardiac procedures at the BPVAMC.

Many cardiologists now believe, contrary to older dogma, that invasive cardiac diagnostic testing (cardiac catheterization) and therapy (angioplasty) may be safely performed in an institution that does not have a cardiac surgery service. We found that American College of Cardiology standards permit percutaneous coronary intervention programs at institutions that do not also offer on-site cardiovascular surgery. The success of these programs is associated with intensive staff training; continuous oversight; and the combination of nearby, readily accessible bypass surgery services, highly experienced interventionalists and support staff, and careful patient selection.

We reviewed BPVAMC cardiac catheterization laboratory service data. We found that there were performance, process, and outcome measures in place. During the 1st and 2nd quarters of FY 2004, the BPVAMC cardiac catheterization laboratory performed 438 cardiac catheterization procedures. Of the 438 cardiac catheterization procedures, 106 included therapeutic interventions (percutaneous coronary intervention [PCI]). None required an emergency transfer to another facility. There were 14 complications as follows: myocardial infarction (1), iliac dissection (2), coronary artery dissection (4), AV fistula (1), bleeding (1), hematoma (2), arrhythmia (1), rash (1), and vasovagal reaction (1). We reviewed these 14 cases and found that 6 occurred in catheterization only procedures and 8 occurred in catheterization plus PCI. There was no mortality, and we concluded that this is an acceptable morbidity rate.

As noted above, the American College of Cardiology calls for a nearby, readily accessible bypass surgery service. We found that the BPVAMC has interhospital transfer agreements with Northside Hospital and Heart Institute and Morton Plant Hospital for cardiac surgery services. In December 2002, the facility tested the emergency transfer system. A mock patient was transported from the BPVAMC catheterization laboratory to Northside Hospital and Heart Institute's operating room in 38 minutes. This was within American College of Cardiology criteria requiring transfer of patients to cardiac surgery facilities within 60 minutes. However, despite this excellent test result, we did not find evidence that BPVAMC managers tested the transfer system quarterly as is suggested by the American College of Cardiology.

Recommended Improvement Action(s) 10. The VISN Director, in conjunction with the Medical Center Director, should ensure that the BPVAMC Critical Care Committee oversee quarterly scheduled drills that test the transfer system of critically ill patients from the cardiac catheterization laboratory to a local hospital with which the facility has a cardiac surgery support agreement.

VISN Director and BPVAMC Director's Comments:

The VISN and BPVAMC Directors concurred with the recommendation and provided acceptable implementation plans. Details of this response are shown in Appendix G, page 153.

Office of Inspector General Comments:

The VISN and BPVAMC Directors comments and implementation plans met the intent of the recommendation. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Dermatology Service Procedure Room Did Not Meet Environmental Standards

From April 1, 2003, to February 29, 2004, Dermatology Service providers performed 1,916 minor operative procedures (skin biopsies, scraping and burning, or skin flaps) in a portable doublewide trailer that did not meet VHA standards. The VHA Heating, Ventilation, and Air Conditioning Design Manual, dated December 2002, requires a constant volume air supply, 100 percent exhaust of the supply air, and individual room temperature control in minor operative suites. The Dermatology Service trailer was designed as office space, and has only a 20 percent exhaust of conditioned air. Recirculated air could increase the risk of infection for patients undergoing minor procedures in the Dermatology Service trailer. Because the Dermatology Service did not have a systematic method to identify, document, or trend post-procedure complications, we were unable to determine the post-procedure wound infection rate in comparison to the community.

Recommended Improvement Action(s) 11. The VISN Director should ensure that the Medical Center Director:

- a. Completes an environmental risk assessment for minor dermatology procedures performed in the portable trailer, and takes action to ensure those procedures are performed in an approved setting.
- b. Establishes a system to identify and track dermatology post-procedure complications.

VISN Director and BPVAMC Director's Comments:

The VISN and BPVAMC Directors concurred with the recommendations and provided acceptable implementation plans. Details of this response are shown in Appendix G, pages 153-154.

Office of Inspector General Comments:

The VISN and BPVAMC Directors comments and implementation plans met the intent of the recommendations. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Medicine Service Did Not Have a Peer Review Process to Monitor Patient Care

On March 22, 2004, a BPVAMC physician testified before the Senate Committee on Veteran's Affairs field hearing, and alleged that the BPVAMC Medicine Service had not had a functioning peer review system since early 2002.

The complainant was the chair of the BPVAMC Medicine Service Peer Review Committee from 1998 to 2001. At the direction of a new Chief, Medicine Service, this peer review committee ceased to be operational. We found evidence that the new Chief, Medicine Service planned to replace the peer review committee with morning rounds. However, while Medicine Service peer review did indeed cease to exist during this time period, we found no evidence that it was, in fact, replaced with morning rounds.

We substantiated the allegation that the BPVAMC Medicine Service had not had a peer review program for the period alleged. In a response to a concern raised, we reviewed the BPVAMC credentialing and privileging process, and found it to be in compliance with VHA Handbook 1100.19, "Credentialing and Privileging."

End of Life Issues

We did not substantiate the allegation that a veteran was not properly cared for and received inappropriate pain medication during his terminal admission to the BPVAMC Hospice.

A 76 year-old veteran was diagnosed with supranuclear palsy (a degenerative Parkinsonian-like illness with severe dementia). Over the 2 years prior to his admission, he slowly declined and was cared for at home by his wife of more than 50 years, with the assistance of home health care services. During the 2 weeks prior to admission, the veteran progressively declined to the point that he was refusing food and could no longer be cared for by his wife at home. On March 12, 2003, he was admitted to the BPVAMC Hospice Unit for palliative/comfort care.

On admission his physical exam was consistent with end stage dementia. An examination of his skin revealed a 19 centimeter (cm) by 11 cm stage II/III decubitus of his left buttock and a 19 cm by 13 cm stage III decubitus of his right buttock. His fists

were locked in position with gangrene noted between his fingers and in the palms of his hands. He was incontinent and required total care.

On March 12, 2003, the dieticians noted in the medical record that he had been fed a thickened pureed diet at home and that he liked grapes. At lunch time on the day of admission, the patient's wife tried to feed him. However, the patient would not swallow, and food had to be eventually removed from his mouth with a cloth. He was judged to have a significant aspiration risk and was, therefore, not fed by the staff.

His skin lesions were assumed to be painful and he was treated with intermittent doses of morphine sulfate, 10-20 milligram (mg) orally, as required, every 2 hours and on March 16, 2003, he had a Fentanyl® transdermal patch (25 micrograms/hour) placed. He was monitored for signs of discomfort.

Throughout this hospice admission, the chart documents many discussions between hospice staff and the veteran's wife regarding his requirement for food and other aspects of end of life care. On March 13, 2003, the chart notes that a visitor with the veteran's wife felt that he should be receiving antibiotics and intravenous fluids. The chart notes that as a result of this discussion, the patient's wife was offered and declined the opportunity to have the patient transferred from the hospice unit to another ward in the hospital for care beyond comfort care. On March 14, 2003, the wife held an extended conversation with the attending physician and the chart reflects that the attending physician felt the patient's wife ended their discussion with a better understanding of end of life issues. On March 16, 2003, the veteran died.

This patient's chart reflects a very high quality of patient care and a high level of concern for the well-being of the veteran's wife. Some may, at the end of life, elect to receive very aggressive therapy. This chart reflects a decision by the veteran's wife to admit this veteran to a hospice unit for compassionate, less aggressive care. The medical care documented in the chart was consistent with the lay pamphlets on end of life care that were available on the Bay Pines Hospice Unit.

Recommended Improvement Action(s) 12. The VISN Director should ensure that the Medical Center Director takes steps to institute a peer review process in all BPVAMC clinical services.

VISN Director and BPVAMC Director's Comments:

The VISN and BPVAMC Directors concurred with the recommendation and provided acceptable implementation plans. Details of this response are shown in Appendix G, page 154.

Office of Inspector General Comments:

The VISN and BPVAMC Directors comments and implementation plans met the intent of the recommendation. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Issue 3: Contracting Procedures and Related Issues

Findings

BearingPoint Received 22 Task Orders Non-Competitively Totaling \$116.5 Million

VA did not allow sufficient¹⁵ time to conduct full and open competition to fulfill the requirements of the CoreFLS project, which was initially budgeted to cost VA \$372¹⁶ million. Instead, the VA Contracting Officer made the award decision based upon an estimated \$800,000 funding amount recommended by the Office of Financial Management (now the Office of the Assistant Secretary for Management) dated November 18, 1999, and a proposal from BearingPoint that represented the lowest price for the first task order. BearingPoint competed against three other vendors for the first task order, which was awarded on December 22, 1999, to BearingPoint for \$750,165.

Because of the insufficient procurement lead time that the Office of Financial Management allowed OA&MM, the Contracting Officer's only option was to use the GSA Federal Supply Service (FSS) Information Technology (IT) Services schedule to contract for services to be provided under the CoreFLS project. After VA awarded the first task order to BearingPoint, they non-competitively awarded BearingPoint an additional 22 task orders through March 31, 2004, for Phases III and IV work. VA made virtually no attempt to negotiate or pursue better prices. As a result of systemic inadequacies in the contracting process, VA's management of the CoreFLS project operated like a blank check for BearingPoint.

At the same time, we recognize that projects of this magnitude and complexity are inherently difficult. As reported by the Department of Transportation (DOT), OIG, in a report titled "Implementing a New Financial Management System," August 7, 2001, DOT along with several other Federal agencies were experiencing significant problems and failures in attempting to implement a core financial system (without a logistics solution) that worked. In addition, the Federal Acquisition Streamlining Act (1994) and the Federal Acquisition Reform Act (1996) had a significant impact on the acquisition environment by changing federal procurement regulations from being more prescriptive to placing a greater emphasis on providing latitude to agencies and their contracting officers.

¹⁵ The contracting office was not presented with the requirement until October 1999 with a requested start date of January 2000. The CoreFLS Project Team requested accelerated contracting but did not provide a detailed statement of work. See also Appendix A.

¹⁶ The Capital Investment Board Application dated July 28, 1999 cited total life cycle costs of \$372 million. The budgeted amount in the FY 2005 Capital Asset Plan Submission now reflects \$472 million.

To prepare for selecting a contractor to serve as an integrator for Phases II, III, and IV of the CoreFLS Project, the CoreFLS Project Team developed a White Paper in November 1999 detailing the acquisition strategy for obtaining integration services in support of Integrated Financial and Logistics Management Standards (IFMS) for the Department. The White Paper, which served as a market research document, provided the Background of the IFMS and the Selection Method. IFMS, as described in the White Paper, represented a Departmental effort to develop and implement a set of business processes that would follow defined standards throughout the VA. The White Paper also noted that VA anticipated that the integrator would serve as VA's implementation partner on the project.

In November 1999, the Contracting Officer had the White Paper published in FedBizOpps.¹⁷ On November 19, 1999, the CoreFLS program office conducted scripted telephone interviews with the 20 firms named in a September 20, 1999, Federal Computer Week article on the top 20 integrators based on reported sales from April 1, 1998, through March 30, 1999. Seventeen of the 20 firms had GSA FSS (Schedule 70) contracts for IT services. After the telephone interviews, the program office reduced the number of potential integrators to seven firms. The program office invited these seven firms to make oral presentations to the CoreFLS Project Team. Each firm received a draft statement of work (SOW), which was expanded from the White Paper to include a more detailed description of Phases II, III, and IV, and which specified the projected periods of performance for all three phases.

Each of the seven firms provided the Contracting Officer with a "rough order of magnitude" of costs by phase and in total. The table below was included in the source selection documentation provided to us by OA&MM. The table contains the "rough order of magnitude"¹⁸ cost estimates and shows most of the costs being incurred in project Phases III and IV. KPMG, now BearingPoint, had the highest total estimate.

¹⁷ FedBizOpps, formerly known as the Commerce Business Daily, is a daily list of federal procurement bidding opportunities.

¹⁸ The firms could not submit a firm proposal because the draft SOW did not contain the necessary detail to prepare a formal proposal.

“Rough Order of Magnitude”

FIRM	Phase II	Phase III	Phase IV	Total	Federal Financial Experience		Acquisition Experience		Implementation Experience	
	Estimate in Millions	Estimate in Millions	Estimate in Millions	Estimate in Millions	Firm	Individual	Firm	Individual	Firm	Individual
Andersen Consulting/ Arthur Andersen/ Birch & Davis	\$20-\$25	\$40-\$45	\$110-\$140	\$170-\$210	✓	✓	✓	✓	✓	✓
Computer Sciences	\$1.4	\$2.8	\$75	\$79.2	✓	✓	✓	✓	✓	✓
EDS	\$3- \$5	\$6-\$10	Phase 4a \$34- \$42 Phase 4b \$110-\$190	\$153-\$247	✓	✓	✓	✓	✓	✓
IBM/Grant Thornton	\$8-\$12	\$10-\$15	\$150- \$223	\$168-\$250	✓	✓	✓	✓	✓	✓
KPMG Peat Marwick	\$1.2-\$1.5	\$1.5-\$2.2	Licenses \$55- \$247 Services \$23- \$73	\$80.7-\$323.7	✓	✓	✓	✓	✓	✓
Price Waterhouse Coopers	\$2-\$3	\$2-\$3	\$125- \$175	\$129-\$181	✓	✓	✓	✓	✓	✓
Sierra	\$.75-\$.9	\$1.5-\$2	\$6- \$10	\$8.25-\$12.9						

After the oral presentations were completed in December 1999, the seven potential integrators were reduced to four. On December 10, 1999, the four firms were provided a SOW that removed the Phase III and IV requirements. The Contracting Officer has been unable to satisfactorily explain why these phases were excluded and the award based solely on Phase II, which was nominal in costs compared to the overall project estimate. Proposals were due on December 17, 1999. The only reference to Phases III and IV in the SOW was in the evaluation factors, which asked each offeror to address, “Other factors that could impact the success of this firm in performing this project (Phase II, Phase III, and Phase IV).” The SOW also asked each firm to address “additional issues” still categorized under evaluation factors. One of these additional issues was, “Describe how the individuals assigned to participate in Phase II would continue participation in Phase III, and broadly describe other individuals who may be added to the team.”

All four firms submitted cost proposals for Phase II, however, only one firm, BearingPoint, submitted proposals for all three phases. BearingPoint submitted a Phase III price range of \$1.2-\$1.8 million and a discount schedule (no proposed price) for Phase IV work. The table on the next page was also included in the source selection documentation, and identifies the four firms and their cost proposals compared to the “rough order of magnitude” proposals they previously had submitted.

Cost Proposals Compared to "Rough Order of Magnitude"

FIRM		Phase II	Phase III	Phase IV	Total
		Estimate in Millions	Estimate in Millions	Estimate in Millions	Estimate in Millions
Andersen Consulting/ Arthur Andersen/ Birch & Davis	R.O.M.	\$20-\$25	\$40-\$45	\$110-\$140	\$170-\$210
AC/AA/ Birch & Davis	Proposal Total Labor	\$ 2,794,730.64	Not Provided	Not Provided	
	(50% Discount	\$ 1,397,365.32			
	Total Labor after Discount	\$ 1,397,365.32			
	Travel	\$ 60,028.10			
	Total Phase II	\$ 1,457,393.42			
Computer Sciences	R.O.M.	\$1.4	\$2.8	\$75	\$79.2
Computer Sciences	Proposal (2% discount labor)	\$2,550,358.0	Not Provided	Not Provided	
KPMG Peat Marwick	R.O.M.	\$1.2-\$1.5	\$1.5-\$2.2	Licenses \$55- \$247 Services \$23- \$73	\$80.7-\$323.7
KPMG Peat Marwick	Proposal Total for Labor	\$ 1,154,100.00	\$1.2-\$1.8	Step Discount based on total order	
	35% Discount	\$ 403,935.00			
	Total	\$ 750,165.00			
Price Waterhouse Coopers	R.O.M.	\$2-\$3	\$2-\$3	\$125- \$175	\$129-\$181
Price Waterhouse Coopers	Proposal Total before Discounts	\$ 2,501,935.44	Not Provided	Not Provided	
	Mgmt & Advisory Discount (50%)	\$ (220,739.76)			
	Other Project Team Discount (15%)	\$ (308,168.39)			
	Project Total After Discounts	\$ 1,970,027.29			

Documentation in the first task order, issued on December 22, 1999, shows that on December 15, 1999, BearingPoint submitted a modification request to GSA, to add a full set of labor categories to the existing general IT labor categories on their FSS (Schedule 70) contract. The labor categories added were "Enterprise Solution" categories, which were used as the categories proposed to VA for the CoreFLS project. On December 16,

1999, the GSA Contracting Officer executed this modification. On December 17, 1999, BearingPoint and the other three firms submitted their proposals to VA.

BearingPoint did not have the key labor categories on their GSA contract at the time of the oral presentations on December 8, 1999, and the issuance of the request for quotation on December 10, 1999. One of the criteria VA used to narrow the field of competition was that the potential contractor had a GSA contract required to perform the services for VA under the anticipated contract. Because BearingPoint did not have the services on a GSA contract at the time of oral presentation, we question whether BearingPoint should have remained in the competition. Instead, VA selected BearingPoint as one of four firms who were provided the SOW and asked to submit a written technical and cost proposal. Although the selection process had been ongoing since November 1999, BearingPoint did not request a modification to its existing GSA contract to add the required labor categories until after selection as one of the final four bidders.

On December 20, 1999, the CoreFLS Project Team met to discuss the submitted proposals. Based on this meeting, BearingPoint was selected for Phase II of the project. This determination was made based on price alone, as all of the firms were found to be technically capable of providing the services solicited. On December 22, 1999, the Contracting Officer issued a task order to BearingPoint for \$750,165. The amount represented a 35 percent discount from the GSA schedule prices.

We question the use of the FSS contract for a procurement of this magnitude. VA contracting officials have told us on several occasions that the use of a GSA FSS schedule relieves the VA Contracting Officer of making a determination that the prices were fair and reasonable. In this case, we question whether GSA could have made that determination given the very short time between BearingPoint's request for a modification to add a full set of labor categories and its execution by the GSA Contracting Officer the next day. At the same time, we recognize that the FSS contract was the only option available to the Contracting Officer given the short time frame that the Office of Financial Management allowed for awarding a contract.

Unlike an FSS supply contract, where prices can be compared for an end product, service contracts are dependent upon a level of effort purchased. There was no evidence in the contract files that rates were compared from one company to the next or that the levels of effort proposed to fulfill the requirements of the SOW were evaluated. Furthermore, as addressed in other sections of this report, once BearingPoint was awarded the first task order, the next 22 task orders (through March 31, 2004) were issued to BearingPoint without competition and with virtually no attempt to negotiate or pursue better prices.

Every task order exceeded the micro-purchase threshold which requires the Contracting Officer to consider reasonably available information about whether the supply or service being procured is available from other vendors on the GSA schedule. We found no

evidence indicating that other integrators were ever considered for Phases III and IV work. As a result, the Contracting Officer never made a best value determination considering other integrators for any of the task orders issued after the initial task order to BearingPoint, even though those orders were for work on Phases III and IV, and represented most of the project costs.

VA's actions with respect to awarding the 22 task orders non-competitively essentially made the CoreFLS project a sole-source award to BearingPoint with the award determination based solely on a very small portion of expected costs and services needed to implement and deploy a CoreFLS solution. As of March 31, 2004, VA had paid BearingPoint approximately \$117.2 million for work performed on 23 task orders without the benefit of having any sites working in an operational status.

The sole-source award to BearingPoint also affected VA's management of task orders issued to BearingPoint. VA allowed BearingPoint to tell them what they would provide under the task orders, as well as how much the task order would cost without VA ever questioning the proposals. As such, VA has been operating the procurement as if they had issued BearingPoint a blank check.

Blanket Purchase Agreement Discounts Valued at \$19.1 Million Were Not Pursued

BearingPoint's initial proposal offered a tiered discount schedule if a BPA was issued to streamline the ordering process. Discounts ranged from 5 to 20 percent based upon the dollar value of the services purchased. The Contracting Officer in her source selection documents noted that BearingPoint had proposed "...a very attractive pricing methodology for Phase IV." VA's estimated purchases would have placed VA in the highest discount tier, which equated to a 20 percent discount off the total dollar value of purchased services. On April 27, 2000, the VA Contracting Officer issued a BPA against BearingPoint's IT (Schedule 70), GSA contract number GS-35F-4338D, as a means of expediting the ordering process and continuing to rely on BearingPoint to provide integrator services for the CoreFLS project. The services to be provided under the BPA correlated to Phase IV of the project as described by VA and reaffirmed by BearingPoint in work plans that referenced the BPA.

As further evidence that BearingPoint recognized what Phase IV services entailed, on January 19, 2000, they presented a report to VA titled the "*Integrated Financial and Logistics Management Standards (IFMS)/Core Financial and Logistics System (CFLS) Accelerated Acquisition Strategy*." This report was one of the required deliverables under the first task order issued to BearingPoint on December 22, 1999. Within this document, BearingPoint described Phase IV as follows:

“Train, test, prototype, implement COTS system and extensions.
Period of Performance: October 1, 2001 to September 30, 2002.”

VA's Document Management System (DMS) intranet site reflects payments of \$95.7 million¹⁹ for task orders issued from November 1, 2001, the date the first task order was issued against the BPA, through March 31, 2004. During this period, all of BearingPoint's work plans have referenced the BPA and were incorporated by reference into the task orders. VA should have received at least \$19.1 million in discounts based on applying the discount schedule²⁰ to \$95.7 million in payments to BearingPoint under the BPA.

On May 5, 2004, we sent an e-mail to BearingPoint's Managing Director. We notified him that VA had never received the discounts that BearingPoint proposed for Phase IV services. We further asked him to respond as to how BearingPoint planned to compensate VA for the offered discounts. In response to our e-mail, BearingPoint said they will offer the discounts commensurate to the cumulative amount of services purchased in the implementation/deployment phase, and as a result BearingPoint does not owe the VA a rebate. However, we have concluded that CoreFLS is in the implementation/deployment phase and, as such, VA is entitled to discounts.

We also verified that all task orders issued against the BPA did not already take into account the discounts. The rates used to establish the task order values were the same basic rates specified in the GSA schedule contract. Thus, VA has received no discounts for Phase IV services.

In discussing the matter with the Contracting Officer who issued the BPA, she stated that it does not matter whether the discount schedule is included in the BPA because the BPA is not an enforceable document because no consideration had passed between the parties to the BPA. We disagree. We agree that the BPA as a stand-alone document is not a contract because there is no obligation on the part of VA to place orders against it. However, once a task order is issued against the BPA, its terms are enforceable. In this case, numerous task orders were issued against the BPA and VA has been invoiced \$95.7 million. Therefore, if the Contracting Officer had included the offered discounts VA would have saved at least \$19.1 million.

¹⁹ Payment data was obtained from VA's Financial Services Center DMS intranet site using purchase order numbers. We also obtained payment data directly from the on-line VA FMS using vendor numbers as an independent verification of the data obtained from the intranet site. The \$95.7 million represents 76 percent of total payments to BearingPoint through March 31, 2004.

²⁰ The discount schedule called for 5 percent discount for purchases up to \$10 million, 10 percent for purchases of \$10-29 million, 15 percent for purchases of \$30-49 million, and 20 percent for purchases over \$50 million.

BearingPoint Was Fully Aware That They Were Operating in Phase IV and That the Discount Schedule Applied

The BPA clearly was for Phase IV services. In addition to the previously mentioned January 19, 2000, deliverable from BearingPoint to the CoreFLS Project Team wherein BearingPoint described Phase IV services, the first task order issued against the BPA on November 1, 2001, contained a work plan, that was drafted by BearingPoint, specifying that the task order would be issued against the BPA. Clearly, BearingPoint knew that the services provided were related to Phase IV of the project.

Response from Certain Members of the CoreFLS Project Team Regarding Phase IV Discounts

Early in our review of contract documents it became apparent that BearingPoint had provided Phase IV services and that BearingPoint had proposed a discount structure related to these services. When our review showed that VA had not received any discounts, we brought this matter to the attention of the Contracting Officer who had issued the BPA to BearingPoint. We also notified the current Contracting Officer regarding Phase IV discounts. He responded: “We are not collecting discounts, Schedule 70 BPA references discounts for Phase IV, we are not in Phase IV so no discount would apply.” Further comments received from the current Contracting Officer and from OA&MM’s Executive Assistant indicated that their understanding that VA was in Phase II and not Phase IV was based on statements attributed to the Acting Project Director for CoreFLS.

We concluded that if the project was not in Phase IV, then at least two very significant situations exist: (i) budget submissions have been incorrect and (ii) the CoreFLS project is far more seriously over budget than previously recognized. In reviewing budget submissions and other documents, we noted the following:

- Page 11 of the Fiscal Year 2003 (submitted in February 2002) Capital Asset Plan for the CoreFLS project states: “Currently, we have completed Phases I, II and III of the project, which comprised the planning and acquisition stages of the project, Phase IV, Enterprises Build and Implementation Phase is underway.”
- The plan goes on to state that “The first Enterprise Build was conducted at the Fayetteville, NC Medical Center in the November/December 2001 time frame.”
- The plan, on page 17, briefly describes Phase II as acquisition planning, Phase III as COTS selection and procurement, and Phase IV as enterprise build and implementation.²¹

²¹ This submission adds Phases V, VI and VII described as Deployment and Training, Rollout, and Maintenance with budgeted amounts of \$67.6, \$65.5, and \$41.4 million, respectively.

- The November 1999 White Paper described Phase IV as consisting “of prototyping and implementation of the enterprise-wide CFLS²² application. Expert advice and technical assistance will be needed from the Integrator during this critical phase. Currently VA anticipates that the integrator would serve as VA’s implementation partner during Phase IV.”

Based on the responses to our inquiries, we realized that the OA&MM contracting office was relying on the CoreFLS program office to tell them what phase the CoreFLS project was operating in. Because the CoreFLS operational structure and timeline that originally were developed and used as a basis for the acquisition strategy, pre-award review, and final contract award were based on a phased approach (Phases I, II, III, and IV), the correct interpretation of various contract documents depended on knowing what phase the CoreFLS project was actually operating in. Through a review of documents dating from before the Integrator contract award to BearingPoint in December 1999 through March 2004, and meetings with the Acting Project Director, CoreFLS, and OA&MM contracting officials, we determined that in June 2002 the CoreFLS program office had altered the operational structure and timeline from the originally developed phased approach to a milestone approach. The Acting Project Director informed us that the former Assistant Secretary for Information and Technology directed that the project be re-baselined using a milestone approach in order to meet certain Office of Management and Budget (OMB) requirements. In this report we are not taking a position on the merits of re-baselining the project. However, it is our conclusion that the decision to re-baseline the project vis-à-vis the original project phases did not take into account the effect this would have on contract administration. The re-baselining caused the confusion as to what phase CoreFLS was operating in. As a result, contract documents, such as the BPA that referenced Phase IV services, could not be effectively administered by OA&MM.

In Appendix B, we discuss our analysis of the relationship between the originally developed phased approach and the re-baselining to a milestone approach. On May 10, 2004, in a meeting with the Acting Project Director and OA&MM contracting officials, we provided the Acting Project Director our schematic representation of the relationship and requested her comments to our position that the project is currently in Phase IV as originally baselined. At the same time, an OA&MM contracting official asked the Acting Project Director to provide OA&MM a document identifying the relationship between the originally developed phased approach and the milestone approach. We have not received any determination from either OA&MM or the CoreFLS Project Office responding to our position.

²² CFLS is synonymous with CoreFLS.

Administration of the BearingPoint Contract Was Inadequate

We requested all files for the 23 task orders issued to BearingPoint by VA's Acquisition Operations Service, which was the designated contracting office for the BearingPoint contract. We reviewed the task order files for orders issued from December 22, 1999, (the date of the first task order) through January 29, 2004, to determine if:

- Each task order file contained SOWs.
- Each task order file contained technical evaluations.
- Independent Government cost estimates were contained in each task order file.
- There were justifications for extending task orders.
- There was justification for increasing task order funding beyond the agreed upon work plan.
- The type of task orders issued to BearingPoint was appropriate for acquiring Integrator services.

We concluded that VA's overall contract administration was inadequate. In addition to systemic weaknesses in contract administration, we identified problems unique to specific task orders. One of the problems involved the ratification of an unauthorized commitment. Another problem involved an award fee paid to BearingPoint. Our review of the task order files showed the following systemic weaknesses:

SOWs Were Not Independently Prepared by VA or Were Nonexistent

In the Interim Report, we questioned the authorship of SOWs that we were able to locate in the contract files. On April 20, 2004, the CoreFLS Project Team responded:

“We can understand why the question has been raised regarding the process for developing the SOWs. However, we do believe that the SOWs were, in fact, developed by the program office and reflect the legitimate requirement of CoreFLS. Nonetheless, we acknowledge that the SOW development process can be improved and we have identified a viable remedy.”

The remedy was to hire an independent contractor with the necessary expertise to assist both the contracting office and the program office in developing independent Government estimates, SOWs, evaluating proposals, and assisting in negotiations with the contractor.

After issuance of the Interim Report, we expanded our evaluation to include the review of 23 task orders²³ and 14 modifications²⁴ to determine if the files contained SOWs independently prepared by VA. We found that the first task order, G07037, was the only one for which VA had prepared a SOW independent of the contractor's work plan. The SOW for task order G07037 was identical to that used for the Phase II solicitation, which VA had prepared to solicit the services of an Integrator.

Of the remaining 36 contract actions, 22 were task orders and 14 were modifications to the task orders. Thirty-one of these contract actions required a SOW. Nineteen of the 31 contract actions had no SOWs in the task order files. For the remaining 12 contract actions, we concluded that the SOWs appeared to have been drafted by BearingPoint. Our conclusions are based on the fact that the SOWs illustrated one or more of the following conditions: (i) dated the same day as BearingPoint's proposal; (ii) copies of BearingPoint's proposal with the letterhead and opening paragraph removed; (iii) dated after BearingPoint's proposal; or (iv) almost identical in wording except for minor changes such as changing BearingPoint to contractor. (Appendix C contains a task order matrix indicating whether the task order files contained SOWs and whether VA independently prepared the SOW, technical evaluations, and independent Government cost estimates.)

Technical Evaluations Were Inadequate or Nonexistent

In the Interim Report, we stated that technical evaluations either were not adequate or were nonexistent. The CoreFLS Project Team disagreed and said the program office had identified an acceptable process of evaluating technical proposals. At the same time, the project team acknowledged that the technical evaluations could be enhanced and again proposed hiring an independent contractor to assist the contracting and program offices in evaluating proposals.

In the evaluation conducted after the issuance of the Interim Report, we found documentation of some level of technical evaluation for 14 of 23 task orders and 3 of 13²⁵ modifications. We also found that the conclusions were identical in all 17 of the evaluations. The evaluations were conducted by the program office and were titled "Technical Analysis/Price Reasonableness Determination by Technical Representative." The technical evaluation was a 1-page pro forma document that provided for the selection of one of the following four choices.

²³ Task orders J07122 and J17073 contained multiple task orders under the same task order number. The task orders differ by functional task to be performed based on the work breakdown structure.

²⁴ We did not include modifications that simply added incremental funding, or contained no substantive change to the task order.

²⁵ For 1 of the 14 modifications reviewed, a technical evaluation was not applicable.

1. The technical representative concurs in the proposed technical approach. No exception is taken to the technical proposal.
2. The technical representative does not concur in the proposed technical approach. Exception is taken to the proposal as follows: [Evaluator would complete a narrative that explains the exception taken].
3. The technical representative concurs in the proposed labor hours, labor categories, skill mix, number of the persons proposed, and other issues. No exception is taken to the proposal.
4. The technical representative does not concur in the proposed labor hours, labor categories, skill mix, number of the persons proposed, and other issues. Exception is taken to the proposal as follows: [Evaluator would complete a narrative that explains the exception taken].

All 17 technical evaluations contained an affirmative answer to number 3. None of the technical evaluations questioned or made recommendations concerning BearingPoint's proposed technical effort or proposed price, nor was there any documentation showing how the reviewer reached the conclusion that he/she concurred in the proposed labor hours, categories, and skill mix. Technical evaluations are the responsibility of the CoreFLS program office and should have addressed the qualitative and quantitative aspects of BearingPoint's work plans. We concluded that work plans proposed by BearingPoint were accepted without detailed review or comments. This represents a weakness in contract administration and program management and resulted in VA giving a blank check to BearingPoint.

Independent Government Cost Estimates Were Missing

In the Interim Report, we stated that several independent cost estimates were missing. We noted that we located two independent Government cost estimates. After further review, we concluded that there were no independent Government cost estimates. The two cost estimates we originally thought existed were part of the CoreFLS COTR's technical review and were for the same price as proposed by BearingPoint. (Appendix C "BearingPoint Task Order Matrix" contains task order files and modifications reviewed and notes the missing independent Government cost estimates.)

We reviewed all 23 files for task orders issued to BearingPoint that were maintained by the contracting office and the program office. None of the files contained independent Government cost estimates. In response to our inquiries on the issue, the initial Contracting Officer essentially confirmed our finding when she told us that the cost estimates are not required by the FAR. We asked the Acting Project Director if the program office completed independent Government cost estimates as part of their

technical and cost analysis. The Acting Project Director stated that they would have to check their documentation. When the Acting Project Director did not provide us with any documentation, we concluded that none existed.

Although not specifically required by the FAR, the independent Government cost estimate is an integral part of the contracting process. The Contracting Officer as a custodian of Government and taxpayer funds has a fiduciary responsibility to make prudent business decisions. An independent Government cost estimate provides a basis for determining the appropriateness of a contractor’s proposal. Additionally, GSA ordering procedures specify that the ordering agency is responsible for considering the level of effort and mix of labor proposed to perform a specific task being ordered in order to make a determination that the total price is fair and reasonable. Without an independent Government cost estimate to compare to the contractor’s proposed price, it is difficult to determine the reasonableness of the contractor’s proposed prices. The proper assessment and documentation of cost estimates is an essential management control.

There Were Task Order Deficiencies

During our review of task order files, we noted several deficiencies in the administration of the individual task orders. The table below shows the deficiencies we identified.

Task Order Deficiencies

Condition	Task Order Number									Note
	G07037	J17073	J27012	J27205	J27234	J37184	J37237	J47061	J47118	
Funding not Associated with Specific Tasks		X								a.
Funding Increased without Justification	X									b.
Follow-on Task Orders were not Sufficiently Documented		X		X						c.
Modifications Change Work Breakdown Structure			X							d.
Cost Increase without Justification			X							e.
Work Plan Dated after the Technical Evaluation Completed							X			f.
Purchases of Software not Covered by SOW				X						g.
Period of Performance Extended after Task Order Expiration							X			h.
Work Commences Prior to Award/Obligation of Funds					X	X		X	X	i.
Request for Proposal Differs from Work Plan					X					j.
Multiple Task Orders Issued Against Same Work Plan							X		X	k.

- a. Funding Not Associated with Specific Tasks. On February 1, 2001, four task orders were issued using the root number J17073. The orders covered program management, technical infrastructure, COTS software, and deployment. Each task order contained a separate funding amount. The orders were identified as J17073PM, J17073TI, J17073COTS, and J17073DEP. On July 1, 2001, there were four individual modifications to these task orders (one for each order). The last modification, dated September 27, 2001, covered all four orders and extended the period of performance from October 1, 2001, to October 10, 2001. The funding for this modification covered all four orders without identifying the allocation of funding by task order. Each task order is unique and requires its own funding. The September 27, 2001, modification did not identify which order the funding applied to.
- b. Funding Increased Without Justification. In reviewing the task order file for G07037, we noted that modification number 2, dated June 1, 2000, added \$631,416 of funding without justification. There was no signed copy of the task order in the file. This modification almost doubled the initial task order for \$750,165 that was awarded on December 22, 1999, for Phase II services.

During our review of the CoreFLS program office file, we found a May 16, 2000, work plan submitted by BearingPoint for the exact amount of the modification. Although the contract file did not include this work plan, or any other documents justifying the need to increase funding, the existence of the plan does indicate that the modification covered additional work. Proper justification for the additional work and funding should have been documented in the task order file.

- c. Follow-On Task Orders Were Not Sufficiently Documented. Task order J17073 was a follow-on task order to the work performed under task order J07122, which expired on January 31, 2001. A January 17, 2001, e-mail in the task order file from the Contracting Officer to BearingPoint requested the company to provide "...which work streams and what the dollar amount is" for the follow-on time period. BearingPoint's response stated "...the estimate is crude - \$6.3M for 5 months. The burn rate will remain fairly steady, I just haven't determined the next logical time slice (period of performance)." Based on this documentation, we concluded that BearingPoint, not VA, was determining the nature and extent of work to be performed.

The file for task order J27205 contained a May 30, 2002, Memorandum for Record from the Contracting Officer's Team Leader, asking BearingPoint to provide a proposal for a follow-on task order to provide integrator services. The memorandum does not identify the specific tasks that BearingPoint was to perform under the order, nor is there any file documentation identifying the specific tasks. Requests to the contractor for proposals should be supported by written documentation detailing the tasks VA expected to be performed.

- d. Modifications Change Work Breakdown Structure. On November 1, 2001, task order number J27012 was issued with an initial period of performance from November 1, 2001, to February 28, 2002. On February 27, April 1, and April 30, 2002, the task order was modified, with each modification extending the order by 1 month and adding deliverables to the task orders. With each modification, the work breakdown structure changed to identify different tasks and sub-tasks. As a result, VA could not match invoices to the level of effort expected on the original task order or any of the modifications. The work breakdown structure should remain consistent in each task order for tracking purposes and contract oversight.
- e. Cost Increase Without Justification. Task order number J27012 had a total period of performance of November 1, 2001, to May 31, 2002. The last modification, number 5, dated April 30, 2002, provided a one-month extension from May 1, 2002, to May 31, 2002, at a price of \$2,503,168 for the month of May. The initial award on November 1, 2001, as well as subsequent modifications dated February 27, 2002, and April 1, 2002, were awarded at a fixed monthly price of \$1,767,916. Modification number 5 had a price increase of \$735,252, or 42 percent, without documentation in the file to justify the reasons for the increase.

Although the deliverables due under modification number 5 were different, the absence of an independent Government cost estimate and a work plan with hours and costs by task further demonstrate the lack of adequate contract oversight.

- f. Work Plan Dated After the Technical Evaluation Completed. Task order J37237 was awarded on June 1, 2003, with a period of performance from June 1, 2003, to December 31, 2003. The work plan was dated May 31, 2003, and the technical evaluation was dated May 20, 2003.

Technical evaluations should be based on the contractor's work plan and, if applicable, should be amended to reflect revised work plans. In this instance, the technical evaluation preceded the work plan by 11 days.

- g. Purchase of Software Not Covered by SOW. Software costing \$627,000 was purchased under task order number J27205 and billed under the subject task order at the direction of the CoreFLS Budget Analyst. Services performed under a task order need to be within the scope of the order. The software purchase was not part of the SOW, and the software should have been procured under a separate purchase order.
- h. Period of Performance Extended After Task Order Expiration. On June 10, 2003, task order number J37237 was issued with a period of performance from June 1, 2003, to December 31, 2003. The award document stated the contractor's proposal²⁶ was

²⁶ The reference to proposal is synonymous with work plan.

incorporated therein, which created an inconsistency because the contractor's work plan indicated a period of performance from June 1, 2003, to November 1, 2003.

On December 3, 2003, modification number 3 extended the period of performance from December 1, 2003, to December 31, 2003. This also was inconsistent with the dates in the task order and in the work plan. More importantly, all deliverables under the task order were delivered by November 30, 2003, thus making the modification unnecessary.

The difference in the periods of performance between the work plan and award document created ambiguity. However, the documentation makes it clear that the deliverables were completed by November 30, 2003. The task order was a firm-fixed-price order and not a level of effort order whereby labor hours are essentially purchased. Because all the deliverables were received by November 30, 2003, we were unable to determine from the file documentation what additional services, if any, were provided for the funded amount of \$4,660,791 during December 2003.

i. Work Commenced Prior to Award/Obligation of Funds. The following are examples where the work began before the award of a task order and/or obligation of funds:

- Modification number 3 to task order J27234 was signed October 11, 2002, with an effective date of October 1, 2002. The work plan in the file was dated October 3, 2002, and the technical evaluation was dated November 14, 2002.
- On April 16, 2003, task order J37184 was awarded with a period of performance from March 1, 2003, to August 30, 2003. The work plan was dated March 28, 2003, and the technical evaluation was dated April 8, 2003. Work on task orders should not start prior to award of such task order. Contractors should be aware that performing work prior to obtaining a valid task order is done at the contractor's risk.
- The file for task order J47061²⁷ was missing the original award document. Based on modification number 1, dated February 11, 2004, the original award was for \$504,000. The only document, a form 2138 fund certification, indicates funds were obligated on November 17, 2003. The period of performance indicated in the work plan was October 1, 2003, to February 29, 2004. Based on modification

²⁷ On May 17, 2004, we submitted this finding to the Contracting Officer for his comments. On June 2, 2004, the Contracting Officer provided an IFCAP funding document signed by BearingPoint on December 8, 2003, that was used as the award document. The document is deficient in the fact that it does not identify the period of performance and does not reference a statement of work or a work plan. The document, as drafted, is not an acceptable format for awarding a task order.

number 1 and the funding document in the task order file, it appears that work on the task order was started before award.

- On January 29, 2004, task order J47118 was awarded with a period of performance of January 1, 2004, to March 31, 2004. The work plan stated a period of performance of December 1, 2003, to March 31, 2004. Based on the documentation, it appears that BearingPoint performed services from January 1, 2004, to January 28, 2004, before the date of award on January 29, 2004, without approval. In addition the task order and the work plan identified a different period of performance.

On June 2, 2004, the Contracting Officer, in response to our request on May 17, 2004, provided a revised statement of work that was not in the contract file provided to us that indicates the period of performance was January 1, 2004, through March 31, 2004. The Contracting Officer stated that the Director, Acquisition Operations Service, issued verbal approval to BearingPoint to continue performance from January 1, 2004, to January 9, 2004. The Contracting Officer also stated that the Deputy Director, Acquisition Operations Service, issued a Notice to Proceed via an e-mail²⁸ to BearingPoint on January 9, 2004, extending the period of performance to January 23, 2004. This extension was to allow time for the Contracting Officer to obtain revised proposals and statements of work and award the task orders.

Although the period of performance issue is accounted for, the delays in issuing new tasks orders has created periods where BearingPoint has operated under verbal authorization. Other than the Contracting Officer's statements, there is no written documentation to substantiate the verbal authorization or what work was to be performed during the questioned time frame. The use of verbal authorizations to continue work is a material weakness and shows a lack of proper contract planning and administration.

- j. Request for Proposal Differed From Work Plan. Task order J27234 was issued at the request of the CoreFLS Program Director in a letter dated June 28, 2002, to the Contracting Officer. The letter requested that the Contracting Officer have BearingPoint submit a proposal for 21 extensions.²⁹ On July 17, 2002, BearingPoint submitted a work plan for 17 of the 21 extensions. Four extensions were not proposed. In addition to the 17 extensions proposed, BearingPoint added an extension

²⁸ There is an e-mail dated January 8, 2004, from the Deputy Director, Acquisition Operations Service, to the Contracting Officer that he would send a Notice to Proceed to BearingPoint. There is no documentation of the Notice to Proceed or any verbal authorization.

²⁹ An extension is a deliverable under the task order.

titled “Extension Environment Instance Management” at a price of \$743,360. The proposed total price for the task order was \$3,019,230. The additional task represented 25 percent of the proposed price. However, there was no documentation in the task order or program office files to demonstrate the need for the task or to document a review of the proposed task price. The contracting office provided funding documents only.

- k. Multiple Task Orders Issued Against Same Work Plan. Our review noted that there were instances where multiple task orders were issued against the same work plan. The documentation indicates that these orders provided additional funding for the original task orders. However, there were no award documents in the task order files, and the documents could not be located by the contracting office.
- Task order J37237 approved BearingPoint’s work plan for \$24,882,008. The same work plan was noted in program office files for task orders J37234, J37325, and G37147.
 - Task order J47118 approved a work plan for \$17,694,077. The same work plan was noted in the program office file for task order J47077.

We could not determine why multiple task orders were issued for the same work plan. The lack of proper documentation is a weakness in contract administration.

On May 17, 2004, we submitted this finding to the Contracting Officer for comment. On June 2, 2004, we received a response which stated that the reason for the multiple task orders is that each time incremental funding was placed on a task order, IFCAP creates a new task order number or tracking number. It appears that IFCAP is limited when incremental funding is used on contracts. Therefore, it becomes important that contract files adequately document what is taking place and should be cross-referenced to each another. Without proper tracking, it is possible with the frequent changing of Contracting Officers, that the approved work plan value could be exceeded if new task orders are created each time funding is added to a task order. The Contracting Officer needs to keep track of all task orders relating to a particular work plan.

Type of Task Orders Issued to BearingPoint Was Inappropriate for Acquiring Integrator Services

Our review of the task order files showed that all task orders were issued to BearingPoint as firm-fixed-price and contained significant assumptions³⁰ that the CoreFLS Project

³⁰ By assumptions we mean specific conditions that VA must meet in order for BearingPoint to successfully deliver their requirements under the task order.

Team accepted when issuing task orders. The assumptions in each order included subjective terms such as timely, adequate, effective, sufficient, and necessary, without criteria to measure when VA would have complied with the assumption. The use of subjective terms without criteria to measure compliance makes it difficult, if not impossible, to measure BearingPoint's performance vis-à-vis VA's expectations. The volume of assumptions ranged from a half page of assumptions on a \$154,000 task order to seven pages of assumptions on a \$25 million task order.

The significant number of assumptions shows that the uncertainties in the tasks to be performed could not reasonably be identified. Using a firm-fixed-price task order when the deliverables were vague would make it difficult to develop reasonable offers. Conversely, a time-and-materials task order would, at a minimum, have ensured that contractor personnel performing work on the task order were identified by name and labor category when invoicing for work performed. This would have allowed VA some oversight as to whether the personnel approved to work on the order were delivering the hours specified in the monthly billings.

We noted that a recently awarded task order (J47207) included a "key personnel" clause. Even though this task order also is firm-fixed-price, we recommend that the use of the key personnel clause (as written in task order J47207) and the use of a time-and-materials task order would greatly improve VA's control over the services provided and billed for by BearingPoint.

All tasks orders issued to date under the GSA IT or Management, Organizational, and Business Improvement Services (MOBIS)³¹ schedules were firm-fixed-price orders. Firm-fixed-price orders are the preferred ordering method under the GSA schedules. The ordering procedures in BearingPoint's GSA IT contract state:

"A firm-fixed-price order shall be requested, unless the ordering office makes a determination that it is not possible at the time of placing the order to estimate accurately the extent or duration of the work or to anticipate cost with any reasonable degree of confidence. When such a determination is made, a labor hour or time-and-materials proposal may be requested. The firm-fixed-price shall be based on the rates in the schedule contract and shall consider the mix of labor categories and level of effort required to perform the services described in the statement of work. The firm-fixed-price of the order should also include any travel costs or other incidental costs related to performance of the services ordered, unless the order provides for reimbursement of travel costs at the rates

³¹ Although many documents reference the MOBIS contract, we only have record of one instance that the GSA MOBIS contract was used. However, the MOBIS GSA contract continues to be available for use so we have incorporated it into our general discussion.

provided in the Federal Travel or Joint Travel Regulations. A ceiling price must be established for labor-hour and time-and-material orders.”

Types of contracts and their proper uses are defined in the FAR.

FAR 16.103 (b) states: “A firm-fixed-price contract, which best utilizes the basic profit motive of business enterprise, shall be used when the risk involved is minimal or can be predicted with an acceptable degree of certainty. However, when a reasonable basis for firm pricing does not exist, other contract types should be considered, and negotiations should be directed toward selecting a contract type (or combination of types) that will appropriately tie profit to contractor performance. The objective is to negotiate a contract type and price that will result in reasonable contractor risk and provide the contractor with the greatest incentive for efficient and economical performance.”

FAR 16.601(b) states: “A time-and-materials contract may be used only when it is not possible at the time of placing the contract to estimate accurately the extent or duration of the work or to anticipate costs with any reasonable degree of confidence.”

FAR 16.601(b) (1) states in part: “...appropriate Government surveillance of contractor performance is required to give reasonable assurance that efficient methods and effective cost controls are being used.”

The uncertainties created by the assumptions underlying the firm-fixed-price task orders could lead to higher task order prices or claims filed by the contractor for VA’s failure to meet their obligations as identified in the assumptions.

On April 20, 2004, we received comments from the CoreFLS project office to our Interim Report that included the following statement: “Approximately 6 months ago, the acquisition process for all task order actions (for all CoreFLS contractors) was being shifted from time-and-materials orders to firm-fixed-price orders.” Notwithstanding the CoreFLS Project Team’s comment, we noted that time-and-material task orders were issued to other vendors providing services related to the CoreFLS project. However, all of the task orders issued to BearingPoint from the first order on December 22, 1999, through March 31, 2004, were firm-fixed-price. The original Contracting Officer also advised us that the task orders that she was responsible for were firm-fixed-price because that was the philosophy of the acquisition office.

While the most recent task orders do attempt to tie award dollars to deliverables, this action does not make them time-and-materials or labor-hour task orders, nor does including a key personnel clause. A time-and-materials task order would, at a minimum, ensure that the personnel performing work on the task order are identified by name, labor

category, rate, and level of effort when invoicing, which would allow VA some oversight over whether the personnel approved to work on the project are delivering the hours specified in the monthly billings.

There Was Conflicting Documentation in the Ratification of an Unauthorized Commitment Under a Task Order

As of November 25, 2003, the ratification of an unauthorized commitment was underway by the Team Leader, CoreFLS contracting team, under the subject task order. Based on the documents provided, we concluded that BearingPoint submitted a work plan dated October 9, 2003, to the Contracting Officer for extensions and extension changes identified as BP36-69. BearingPoint's proposed price was \$1,887,071, which consisted of labor in the amount of \$1,761,071 and estimated travel of \$126,000. BearingPoint proposed labor that would be billed over six invoices from September 2003 through February 2004 in equal amounts of \$293,512 (rounded) plus travel. The period of performance identified in the work plan was October 1, 2003, to February 29, 2004, which conflicts with the payment method identified in the same work plan (i.e., 5 months rather than 6 months). On November 6, 2003, BearingPoint submitted exactly the same work plan as previously submitted to the Contracting Officer on October 9, 2003. Although BearingPoint commenced work, the Contracting Officer had not authorized the work, nor had funds been obligated.

The difficulty in determining the time period covered by the unauthorized commitment and the value of the work performed by BearingPoint are the result of conflicting documents contained in the ratification and task order files as addressed below:

- In a letter dated November 25, 2003, to the Team Leader of the CoreFLS contracting team, BearingPoint requested payment of \$587,023 for work performed on extensions BP36-68 for the period of October 1, 2003, to November 26, 2003. This letter also stated that as of November 26, 2003, BearingPoint would cease all work on the Build 1.3 development effort in accordance with the Team Leader's direction.
- The contract file is missing the original award document for task order J47061. However, the file does contain a funding document dated November 17, 2003, that provided funding of \$504,000 on the order. This indicates that work started in November 2003. Therefore, the period covered by the ratification should be October 1, 2003, to November 17, 2003, not November 30, 2003.
- On December 4, 2003, the former CoreFLS Project Director submitted a request for ratification of unauthorized commitment. The request stated the time period covered by the ratification was October 1, 2003, to November 30, 2003. The amount requested was \$943,536, which included travel costs. The request was submitted pursuant to FAR 1.602-3. The request also stated the steps taken to ensure that

unauthorized commitments would not be used in the future to satisfy like requirements. The request stated that “CoreFLS has spoken with members of the office who are involved in the procurement process and has been informed that the ratification is an extremely serious matter and all CoreFLS personnel are committed to improving their acquisition knowledge and skills.”

- On December 8, 2003, the Contracting Officer sent a memorandum to the Deputy Assistant Secretary for Acquisition and Materiel Management, requesting approval of the unauthorized commitment with BearingPoint for \$943,536. Attached to the request was a work plan dated December 8, 2003, from BearingPoint to the Contracting Officer. The plan showed a period of performance from October 1, 2003, to November 30, 2003, and a total price of \$943,536, consisting of labor costs of \$880,536 and estimated travel costs of \$63,000. The work plan stated labor would be billed on one invoice in December.
- The file also contained an invoice dated March 3, 2004, from BearingPoint for \$880,536 for “billing for professional services rendered during the period of performance October 1, 2003 to November 30, 2003.” The invoiced amount agrees with the labor portion of the Contracting Officer’s December 8, 2003, memorandum, and therefore appears to be the invoice for the ratification. This amount differs from the request for payment submitted by BearingPoint on November 25, 2003, for \$587,023, and we could not find any documentation to explain the basis for the discrepancy of almost \$300,000.

There are many conflicting items of information that need to be reconciled prior to any payment under the ratification.

- The original request from BearingPoint for \$587,023 was for 2 months of labor (October and November 2003). This amount is consistent with the monthly billings identified in BearingPoint’s work plan dated October 9, 2003. However, the current request for approval is for \$943,536, which appears to be based on a work plan submitted December 8, 2003, covering the same time period and the same work as in the original plan. There was no explanation in the file for the increased amount.
- The initial work plan, dated October 9, 2003, referenced a period of performance from October 1, 2003, to February 29, 2004, which differs from the payment schedule for labor in the October 9, 2003, work plan that showed invoices would be billed for September 2003 through February 2004.
- Based on the funding document in the task order file, it is apparent that on November 17, 2003, funding was placed on the task order, which would mean that work had been approved. This also would mean that at the very least the period of performance covered by the ratification should be from October 1, 2003, to November 17, 2003,

and not the full 2 months of October and November 2003 requested in BearingPoint's invoice dated March 4, 2004.

- The amount requested (\$943,536) was not justified. The former CoreFLS Project Director stated in his request for ratification that the dollar value of the benefit was not entirely quantifiable. This statement shows that the program office cannot estimate the cost of the services performed and reinforces the need for independent Government cost estimates. If the program office had developed an independent Government cost estimate for BearingPoint's October 9, 2003, work plan, the value of the services received would be readily identifiable for determining whether the charges are fair and reasonable.

The steps taken by the program office to ensure that unauthorized commitments do not take place in the future are inadequate. We recommend, at a minimum, that all VA CoreFLS employees should be advised, in writing, of contracting procedures and the effect of unauthorized commitments.

In our opinion, the nature and extent of the issues relating to this task order further illustrates the major weaknesses in the overall administration of the contract.

Award Fee Paid Under a Task Order Was Improper

On June 10, 2003, the Contracting Officer issued an award fee task order J37237, which provided for the continued development of the enterprise solution at BPVAMC. The task order provided for a one percent award fee to BearingPoint if they could "...bring the operational test sites³² in a 'live' environment no later than November 11, 2003, and successfully conduct business operations for the remainder of the period of performance."³³ On December 24, 2003, VA paid BearingPoint the award fee of \$227,620. The award fee was not in accordance with the requirements of the FAR or BearingPoint's GSA contract.

Provisions in the FAR and in BearingPoint's GSA Contract Related to Award Fees

FAR 16.404(a) states in part: "...the award fee provisions may be used in firm-fixed-price contracts when the Government wishes to motivate a contractor and other incentives cannot be measured objectively. Such

³² Test sites were BPVAMC, Veterans Benefits Administration St. Louis RO, VACO Financial Services Center, and National Cemetery Administration, Tampa. Award fee was to be paid for these sites to operate in a "go-live" mode.

³³ The original period of performance was from June 1, 2003, through November 30, 2003. Modification 3 extended the period of performance to December 31, 2003.

contracts shall provide for periodic evaluation of the contractor's performance against an award fee plan.”

FAR 16.404 (b) states: “A solicitation contemplating award of a firm-fixed-price contract with award fee shall not be issued unless the following conditions exist: (1) The administrative costs of conducting award-fee evaluations are not expected to exceed the expected benefits; (2) Procedures have been established for conducting the award-fee evaluation; (3) The award-fee board has been established; and (4) An individual above the level of the Contracting Officer approved the firm-fixed-price-award-fee incentive.”

In addition to the cited FAR provisions, which affect all award fee arrangements, BearingPoint's GSA contract includes the following section:

2. PERFORMANCE INCENTIVES

- a. Performance incentives may be agreed upon between the Contractor and the ordering activity on individual fixed price orders or Blanket Purchase Agreements under this contract in accordance with this clause.
- b. The ordering activity must establish a maximum performance incentive price for these services and/or total solutions on individual orders or Blanket Purchase Agreements.
- c. Incentives should be designed to relate results achieved by the contractor to specified targets. To the maximum extent practicable, ordering activities shall consider establishing incentives where performance is critical to the ordering activity's mission and incentives are likely to motivate the contractor. Incentives shall be based on objectively measurable tasks.

There was no documentation in the task order file to show that any of the conditions cited in FAR 16.404(b) or the GSA contract were met. No procedures were established for conducting the award fee evaluation or that an award fee board had been established. We also could not find evidence to show that any evaluation was performed regarding the condition for payment. Given the vague language in the task order and the fact that there is no documented CoreFLS Project Team evaluation of BearingPoint's performance in relation to the payment of the fee, we do not question that the payment was in accordance with the task order. The condition of bringing the operational test sites in a “go-live” mode may well have occurred. However, we question payment of the award fee since the system obviously did not successfully conduct business operations. In our opinion, the recent findings at Bay Pines clearly show that BearingPoint did not successfully conduct business operations at Bay Pines at any time during the period of performance. We also

question whether the other locations ever operated in a “go-live” mode and “successfully” conducted business operations as required for BearingPoint to receive the award fee. Furthermore, if all of the sites did not meet the “go-live” mode criteria or successfully conduct business operations for the remainder of the period of performance, the award-fee payment should not have been made.

Justification for Award Fee Payment

We requested documentation from the CoreFLS program office that would support the payment. We received an electronic copy of an unsigned letter dated December 1, 2003, from BearingPoint to the VA Contracting Officer that simply stated that they had successfully completed the requirements to be paid the award fee. This letter was not in the contracting office’s task order file. Additional documentation provided included a January 5, 2004, e-mail from the former CoreFLS Project Director which contained no references to a “live” operational status or to conducting successful business operations. The e-mail did state “What We Will Be Doing Next: Should we Go-Live, we will engage the CoreFLS Liaisons to evaluate and assist the CoreFLS Project Team with Operational Test Phase 2 activities.” Furthermore, this e-mail was dated after payment had been made. We asked for documentation from the program office to support the two criteria (“go-live” and “conduct successful business operations”), along with evidence that all four sites met the criteria. The program office responded with a copy of the CoreFLS Connection October-November 2003, that contained an article stating that “CoreFLS Goes Live.” This article was not specific on the meaning of “go-live” but did cite all the locations named in the task order requirement as going-live. We do not consider this article adequate documentation supporting the award fee payment.

In our opinion, the lack of a clear condition for payment, the lack of any evidence of an evaluation, and the fact that the provisions of the FAR and GSA regulations were not adhered to are further evidence of the inadequacies in contracting and contract administration. In the future, any contemplated award fee incentives should follow the provisions of the FAR and GSA regulations and be properly documented in order to protect the VA from paying incentives that have not been justly earned by the contractor.

Other Related Matters

Assignment of COTR Should Be Reconsidered

The current COTR also is the Acting CoreFLS Project Director. While there is no specific prohibition on assigning the Acting Director this additional task, we would recommend assigning another COTR because we believe the duties of Project Director and COTR are too onerous for one individual to adequately manage. We reviewed the Contracting Officer’s delegation of authority to the COTR dated April 23, 2004, to determine the depth and breadth of responsibility. The responsibilities of the COTR

position are onerous, especially for a project of this magnitude. Additionally, BearingPoint is only one of several contractors providing services on the CoreFLS project.

Contractor Travel Costs Were Not Adequately Monitored

As of March 31, 2004, VA had paid BearingPoint approximately \$4.2 million for claimed travel costs billed for task order work. Task orders issued before April 26, 2004, provided that BearingPoint could bill for expenses each month, but was required to try to reduce costs by finding competitive fares. By issuing task orders that allowed BearingPoint to bill for actual expenses, the CoreFLS Project Team did not adhere to travel provisions in the GSA FSS contract and the Federal Travel Regulations (FTR).³⁴ Although the CoreFLS program office reviewed BearingPoint's travel vouchers to ensure the math was correct, they often did not review vouchers to ensure that costs were reasonable and allocable to task order work. We also found that the CoreFLS program office did not maintain documentation to show the need for travel and that travel had been adequately planned.

- Air Fares Appeared Excessive. Contractor employees were traveling to the same site for several weeks at a time often incurring significantly higher airfares for one week than for others. Individual airfares often exceeded \$1,000. At other times, contractor employees incurred very high airfares when they purchased tickets just a few days before their trips. The vouchers did not show justifications for the high fares, and CoreFLS reviews did not question the fares. In our limited review of travel vouchers we did not see any unallowable first class travel, rather it appears that the excessive fares are related to the lack of advance travel planning. Without documentation to show that the travel was adequately justified and planned to the extent possible, we were unable to conclude that the airfares were, in fact, excessive.
- Weekend Trips Home Were Not Justified. Contractor personnel who traveled to the same site for several weeks sometimes returned home on weekends and then returned to the site the following week. These trips resulted in additional airfares and other travel related costs. FTR Section 301-11.23 specifies that reimbursement is allowable only if justified incident to an extended temporary duty assignment. Reimbursements for authorized return trips home are limited to the lesser of per diem (including lodging) or the round trip fare home and back to the work site (FTR 301-11.24). No one on the CoreFLS Project Team questioned the reasonableness of these costs.

³⁴ The GSA FSS contract specifies that travel and other incidental costs related to the performance of the services ordered shall not exceed the rates in the Federal Travel or Joint Travel Regulations. BearingPoint employees are required to adhere to the Federal Travel Regulation.

- Vouchers Usually Did Not Indicate Purpose and Necessity of Travel. In general, the vouchers did not cite a business purpose for a trip and did not relate the claimed expenses to specific task orders. FTR Section 301-2.2 provides that agencies may pay only those expenses essential to the transaction of official business. Without such documentation included in vouchers, there is little assurance that the claimed expenses are necessary and allocable to the task orders.

- Planning Was Not Adequate to Determine Reasonable and Necessary Expenses. FTR 301-71.107 (Authorizing Travel) advises that some of the factors to be considered when authorizing travel are:
 - The need for the travel.
 - The use of travel substitutes (mail, teleconferencing, etc.).
 - The most cost effective routing and means of accomplishing travel.
 - Travel plans, including plans to take leave in conjunction with travel.

Based on our limited review of the travel payment approval process, we found little documentation ensuring that BearingPoint's requests for travel reimbursements were reviewed for the above factors.

We discussed the above findings with the CoreFLS Acting Project Director and Budget Analyst and both agreed that BearingPoint's travel vouchers needed closer review to ensure that VA pays for reasonable and necessary expenses rather than reimburse the contractor for actual costs. As a result of our findings, and in an effort to better control travel costs paid for by VA, the "Travel" clause in task orders issued starting April 26, 2004, now requires that BearingPoint submit a Travel Plan to the Contracting Officer within 20 days after award of the task order. The Travel Plan is required to include, but is not limited to:

- Who will be traveling.
- Where the traveler(s) will be traveling to.
- When the travel will take place.
- The purpose of the travel.
- An estimate of the total cost of the proposed travel.

BearingPoint recently paid \$17 million to settle claims that they charged full cost for travel rather than the net cost to them after receiving rebates from travel companies.³⁵ Any comprehensive review of billed travel expenses under the CoreFLS project should include determining whether BearingPoint received any rebates related to travel under the project that they did not pass on to VA.

³⁵ "KPMG and former unit to settle to settle travel bill suit..." WallStreet Journal, April 5, 2004.

Background Investigations of BearingPoint Personnel Were Not Initiated in a Timely Manner

The CoreFLS Project Team did not initiate security background investigations for BearingPoint employees who had access to VA's computer systems until 4 years into the project. We found there were 143 contractor employees, consisting of 39 U.S. citizens, 32 non-U.S. citizens, and 72 of unknown citizenship. Although the first task order was issued in December 1999, it was not until January 21, 2004, that the Contracting Officer issued a task order that initiated the process of obtaining background investigations for the BearingPoint staff.

VA Directive 6210, issued January 30, 1997, requires that personnel security requirements shall be included in all specifications for the acquisition, operation, or maintenance of software and related services, whether procured through VA, GSA, or another agency. Furthermore, the directive requires determinations of position sensitivity designations, risk levels, and necessary screening of both Federal and contractor personnel, and these provisions applied to all VA components. VA's detailed policy on personnel security is contained in VA Directive 0710, dated October 30, 2000, and its related VA Handbook 0710, which is currently under revision. VA Directive 0710 requires that all non-VA employees (such as contractor's employees) who require access to VA's sensitive computer systems must be the subject of a background investigation conducted by the Office of Personnel Management (OPM), and receive a favorable adjudication from VA.

On July 16, 2001, OA&MM published Information Letter (IL) 90-01-6 on the subject of "Contractor Personnel Security Requirements." The IL provided guidance to VA contracting personnel relating to the established background investigation requirements for contractor personnel with access to VA systems. The IL also stated that solicitations and resulting contracts that require contractor access to computer systems designated as sensitive shall contain a section on security requirements and include information about position sensitivity designations and the level of background investigation required for each contractor employee. The IL further provided that contract performance should not begin prior to the initiation of the process to obtain background investigations. The IL indicated contractor employees could work on the contract while the background investigations were being conducted and that during that time, the contractor would be responsible for the actions of its employees.

The Acting CoreFLS Project Director did not initiate background investigations to obtain security clearances because she was unaware of the requirement, and the initial VA Contracting Officer believed the requirement could not be put into a task order because she believed it would have been unenforceable. Additionally, when the CoreFLS Project Team initiated the background investigations, they established sensitivity levels that were lower than required by VA directives. This would have resulted in lower level

background investigations than warranted. Pursuant to our inquiries, the designated sensitivity levels were elevated from “low” to “moderate.” Based on our review of VA directives, we believe that the appropriate minimum risk level is “moderate” and, arguably, should be “high.” The lack of background investigations for the BearingPoint contract employees, many of whom were non-U.S. citizens or of unknown citizenship, increased VA’s risk of sensitive information in its systems being compromised.

On April 22, 2004, we made inquiries to the Acting and former CoreFLS Project Directors regarding the basis of VA’s initial sensitivity designation of “low.” The former CoreFLS Director indicated that he could not locate any information in his files to answer the question, and the Acting CoreFLS Director did not respond. However, the next day (April 23, 2004), the sensitivity designation for contract employees was changed from “low” to “moderate.”

We agree that the sensitivity designation should be at a minimum at the moderate risk level. We requested the CoreFLS team to provide us the required VA forms that establish sensitivity designations (VA Form 2280 titled “Position Sensitivity Level Designation”). On May 12, 2004, we obtained the VA Form 2280 that established the sensitivity level at the “moderate” level, which was signed by the CoreFLS Information Security Officer.

VA policy (IL 90-01-6) requires the cost of background investigations to be paid by the contractor. Although we did not identify the reason that the sensitivity levels for contract employees initially were established at the “low” level, there are significant differences in prices for investigations at the different sensitivity levels. A National Agency Check with Law enforcement and Credit (NACLC) currently used for “low” sensitivity designations instead of the National Agency Check with Written Inquiries costs \$200 versus \$866 for a Minimum Background Investigation (MBI) required for “moderate” sensitivity designations. Therefore, MBIs for the 143 positions will cost \$123,838 (\$866 x 143) instead of the \$28,600 (\$200 x 143) originally envisioned for the NACLC investigations at the low risk levels.

In our opinion, the actions taken by the CoreFLS Project Team, as revised, will meet the intent of VA Directive 0710 if the provisions of the task order are completely and accurately implemented. Accordingly, we are not making any recommendations regarding current BearingPoint employees working on the CoreFLS contract.

However, we believe VA needs to strengthen internal controls over the process of determining sensitivity designations for non-VA employees. VA Handbook 0710 requires the position sensitivity and level of investigation to be determined by the VA organization sponsoring the non-VA employees. The draft revision of VA Handbook 0710 (undated) does not contain this provision, but the Program Analyst in the Office of Security and Law Enforcement informed us that the provision will be retained. In our

opinion, the VA organization sponsoring non-VA employees who will have access to VA computer systems should only be allowed to recommend sensitivity designations. This could preclude cost considerations or other factors as being relevant to the approval decision. Therefore, we are recommending that the VA Office of Cyber and Information Security be tasked with approving the recommended sensitivity designations (and by extension, the level of investigation). To implement the recommendation, VA Handbook 0710 would need to be changed to add the requirement, and a separate version of VA Form 2280 would need to be designed to add an approval signature block from the Office of Cyber and Information Security. Because the completion of VA Handbook 0710 may be delayed, we also are recommending the Office of Security and Law Enforcement take interim actions to ensure the recommendation is implemented pending completion of the revised VA Handbook 0710.

Potential Effect of Untimely Background Clearances. The lack of background investigations for BearingPoint employees increased VA's risk that sensitive data could have been compromised since inception of the project in December 1999. The number of BearingPoint personnel working on the project has averaged 131 on a quarterly basis since December 2002. They would have had access to proprietary VA data to include: (i) purchasing data including quotations, prosthetic and home oxygen orders possibly containing VA patient information subject to the Privacy Act, and pharmacy and dietetics purchase orders; (ii) inventory data including cart re-stock lists, inventory transaction reports, stockroom transfer reports, and inventory lists; (iii) general ledger information including compensation and pension, fee basis, payroll, and insurance journal entries, cost transfers between stations, and other proprietary financial information; (iv) VA budget information; (v) fixed asset and asset management information, including inventory asset retirement, asset transfer, and reconciliation data; (vi) accounts payable processes including invoice adjustments and approvals, debit memorandums, entering employees as suppliers, inter-station transfers, and system interfaces such as credit card purchases, and treasury payment cancellations; and (vii) accounts receivable processes such as the creation of customer entries, invoices, and credit memorandums.

The information that VA contractors have access to on the CoreFLS project is critical to the performance of VA's mission. Accordingly, any compromise of this data could have a significant adverse impact on VA's mission. Compromised VA data could result in misappropriation of funds for personal use, system sabotage through unauthorized software extensions, or unauthorized use of proprietary or Privacy Act information for personal gain.

Recommended Improvement Action(s) 13. The Assistant Secretary for Management should:

- a. Take appropriate administrative actions against responsible CoreFLS management, contracting personnel, and other team members.

- b. Initiate a review of all payments to BearingPoint to determine whether there were any improper or erroneous payments for collection.
- c. If the discounts offered for Phase IV work and/or the award fee cannot be recovered, take appropriate administrative action against the responsible VA personnel.
- d. Award and administer any future award fee provisions in accordance with FAR and the GSA contract provisions, in addition to specifying criteria for evaluation of performance.
- e. Conduct a complete review of all BearingPoint travel vouchers submitted by BearingPoint since commencing work in January 2000 to determine if the claimed costs are allowable in accordance with the provisions of the FTR; (ii) coordinate findings with the Office of Inspector General; (iii) collect any amounts found to be in excess of those allowable under regulations; (iv) clarify return home allowable expenses; and (v) check rebates.

Assistant Secretary for Management Comments:

The Acting Assistant Secretary for Management concurred with the recommendations and provided acceptable implementation plans. Details of this response are shown in Appendix H, pages 160-167.

Office of Inspector General Comments:

The Acting Assistant Secretary for Management comments and implementation plans met the intent of the recommendations. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Recommended Improvement Action(s) 14. The Assistant Secretary for Information and Technology should:

- a. Not award BearingPoint or any other vendor any task orders for CoreFLS integration after the current task order expires June 30, 2004.
- b. If CoreFLS is to be continued, develop a comprehensive SOW for the integration effort, considering all of the “lessons learned” to date, and compete the requirements.
- c. Determine a suitable candidate, other than the current CoreFLS Acting Project Director, to be the COTR for the CoreFLS requirement. This individual should possess the technical expertise to properly monitor performance.

- d. Take action to ensure that all non-VA employees have the appropriate security clearance process initiated before they are allowed to work on the CoreFLS project, if it is continued.

Assistant Secretary for Information and Technology Comments:

The Assistant Secretary for Information and Technology concurred with the recommendations and provided acceptable implementation plans. Details of this response are shown in Appendix I, pages 175-177.

Office of Inspector General Comments:

The Assistant Secretary for Information and Technology comments and implementation plans met the intent of the recommendations. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Recommended Improvement Action(s) 15. The Acting Assistant Secretary for Policy, Planning, and Preparedness should:

- a. Include in the VA Directive and Handbook 0710 currently being amended, a requirement for the Office of Cyber and Information Security to be the approving authority for sensitivity designations for non-VA employees with access to VA systems.
- b. Initiate the process of including an approval signature block on VA Form 2280 for the Office of Cyber and Information Security approval of the sensitivity designation recommended by the VA organizational unit sponsoring the non-VA employees.
- c. Take interim action to ensure that recommendations 15.a and 15.b are implemented pending the completion of the revised VA Directive and Handbook 0710.

Acting Assistant Secretary for Policy, Planning, and Preparedness Comments:

The Acting Assistant Secretary for Policy, Planning, and Preparedness concurred with the recommendation and provided acceptable implementation plans. Details of this response are shown in Appendix J, pages 180-181.

Office of Inspector General Comments:

The Acting Assistant Secretary for Policy, Planning, and Preparedness comments and implementation plans met the intent of the recommendation. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Issue 4: Deployment of CoreFLS

Findings

We found that data conversion needs management attention, employees need sufficient training to use CoreFLS, and management needs to implement prior recommendations from VA's Independent Verification and Validation (IV&V) 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 VistA and Personnel Accounting Integrated Data (PAID). Furthermore, VA CoreFLS management needs to ensure reconciliations and reports are accurate and timely. Many of the problems with the CoreFLS project resulted from the manner in which the project was managed. The effect of the deficiencies and control weaknesses include: 1) increased risks associated with processing timely, accurate, and reliable financial and logistics data and information; and 2) higher costs associated with the implementation of CoreFLS as implementation and testing for other locations is delayed.

The Accuracy of Data Converted to CoreFLS Was Not Validated

In our Interim Report, we reported that VA CoreFLS management did not confirm the accuracy of the applicable fiscal and acquisition legacy information prior to conversion to CoreFLS. For example, the payment cycle field in the "accounts payable" record was not converted accurately, inventory records were inaccurate, vendor files were corrupt, and resource objectives and re-order points were erroneous. In part, this resulted from insufficient procedures necessary to convert legacy data and detect conversion failures.

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 new financial management system. Particular attention needs to be paid to potential problem areas, such as inventories, physical assets, contracts, accounts receivable, or accounts payable.

In response to our interim finding, VA CoreFLS managers reported that comprehensive data cleansing policies, guidelines, and procedures had been developed prior to the initial deployment on October 6, 2003. We were provided data conversion policies, guidelines, and procedures, which consisted of 15 Microsoft PowerPoint presentations. However, these presentations were prepared in February 2004 and March 2004, after the deployment date. Furthermore, the presentations contained insufficient detail related to data conversion procedures. For example, the general ledger conversion plan required the extraction of general ledger data from the legacy system. The plan called for the

verification of data completeness and accuracy. However, the plan did not provide sufficient detail related to determining whether data was complete and accurate.

CoreFLS managers reported that VAMC managers at each site had certified that data conversion was complete, indicating the facilities were ready to begin Operational Test Phase I. However, conversion certifications were not always signed by VAMC managers. For instance, VA CoreFLS managers, not VAMC managers, certified data conversions for DynaMed surgical packs, vendors, and purchase and travel cards.

Employees Did Not Obtain Sufficient Training to Use CoreFLS

Our Interim Report noted that employees did not take or complete the required e-training necessary to operate and maintain CoreFLS. For example, 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 1 of the 51 required accounts payable courses. Similarly, for the inventory module, key employees had not completed the required training. The Chief, SPD had not logged onto any of the required e-training courses. VAMC employees told us that the training did not provide for discussions, the ability to ask questions, or allow for setting aside uninterrupted training time. Also, we were told that CoreFLS management did not provide enough workshops. VAMC employees also told 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.

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 training is to enable users at all levels to understand, operate, and maintain applicable financial management systems.

In response to this interim finding, CoreFLS managers reported that 393 of 694 (57 percent) BPVAMC users had not completed any of the e-training courses. CoreFLS managers plan to implement a training assessment and certification program to ensure users at BPVAMC and future implementation sites are well-trained. In April 2004, BearingPoint had agreed to provide a training material development handbook and a VAMC integrated training plan at no cost. We were not able to assess the effectiveness of the training deliverables because they were under development as of the date of this report.

We found that some training deficiencies had been reported to CoreFLS managers before the October 2003 deployment. On September 29, 2003, VA's IV&V contractor, Access Systems Inc. (Access Systems), reported that some VA employees participating in Build 1.2 test activities could not execute business processes without the assistance of BearingPoint employees. On October 2, 2003, we reported similar observations, after

observing several VAMC employees were unable to perform accounting duties using CoreFLS. On October 8, 2003, BearingPoint began reporting the status of employees logging onto e-training. The report identified low log on rates.

VA Management Did Not Implement Prior Recommendations

Our Interim Report noted that CoreFLS management had not implemented approximately 45 percent of the recommendations made by Access Systems in two IV&V reports issued in April and September 2003. Specifically, Access Systems informed us that CoreFLS management had not implemented 9 of the 14 recommendations made in Access systems' report³⁶ issued on April 30, 2003, and 7 of the 21 recommendations made in the report³⁷ dated September 29, 2003.

Software verification and validation is an important step in the system development life cycle. It ensures 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.

In response to our interim finding, VA CoreFLS managers reported that corrective actions for 6 of the 14 April 2003 recommendations were either in progress or had been determined to be contrary to the CoreFLS development approach. They reported that corrective actions had been completed for 3 of the 21 September 2003 recommendations, and 4 other recommendations were in the process of being implemented.

Access Systems informed us that CoreFLS management had made some progress since February 2004. Even though progress has been made, Access Systems believes that 9 of the 14 recommendations reported on April 30, 2003, and 7 of the 21 recommendations reported on September 29, 2003, remain unresolved. We were unable to identify any written response from BearingPoint or CoreFLS managers to Access Systems regarding the findings and recommendations. Access Systems informed us that in addition to the recommendations discussed above, there are similar circumstances in regard to recommendations reported in the August 29, 2003, Independent Security Test and Evaluation Report.

We also identified concerns pertaining to the independence of IV&V reviews. Access Systems was paid by the VA CoreFLS project, the same organization paying for the development of the software. Furthering this concern was the fact that we observed the

³⁶ "CoreFLS Quality Assurance and Independent Verification and Validation Test Results" dated April 30, 2003.

³⁷ "CoreFLS Build 1.2 QA/IV&V Report" dated September 29, 2003.

IV&V contractor being told to obtain approval from BearingPoint prior to providing system log-on information to the OIG.

NIST Special Publication 500-234 states that managerial independence of an IV&V means the responsibility belongs to an organization outside the contractor and the program organization that develops the software. Financial independence means that control of the IV&V budget is retained in an organization outside the contractor and program organization that develops the software.

VA Employees Were Not Sufficiently Involved in Testing Procedures

Our Interim Report noted that after observing two tests of the system, we concluded that test results may not provide assurances that CoreFLS will meet VA needs. In some cases, we observed BearingPoint employees, rather than VAMC employees, developing and conducting the tests and determining tests results. In one case, we observed that a VAMC tester was not familiar with the business process being tested and required assistance from BearingPoint employees to perform the test. In our judgment, thorough testing throughout the system development life cycle is necessary for optimal system performance. Testing enables VA to ensure that the system works as expected. The lack of reliable test results increases significantly the risk of the CoreFLS system not working effectively.

OMB Circular A-123 states that management controls must provide reasonable assurance that assets are safeguarded against waste, loss, unauthorized use, and misappropriation. 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.

In response to our Interim Report, VA CoreFLS managers stated that test results are reliable and reflect the conclusions of the testers across the numerous scripts executed. Conducting tests when VAMC testers were not available did not happen frequently. Occasionally, in the areas of purchasing and asset management, CoreFLS team members did stand-in for users. In these situations, only VA members of the CoreFLS project team conducted the tests.

However, we remain concerned over segregation of testing duties. In addition to BearingPoint developing test procedures, conducting tests, and recording results, we observed BearingPoint employees providing “over-the-shoulder” direction to VAMC employees on how to execute tests and what results to record. We observed this practice on three occasions. On December 4, 2003, we observed the execution of one test related to the processing of interim transactions through suspense. The BearingPoint employee

told the VAMC employee what data to enter, how to navigate through the test, and what results to record. After the test results were recorded, the VAMC tester stated she did not understand the test. We made similar observations on August 27 - 28, 2003, during the execution of tests related to procuring material for work orders and transferring of capital assets.

Our Interim Report also noted concerns about performance results to support the 8-second end-to-end response time during peak demand across the network. In addition, we reported that performance measurement and monitoring methods may not provide accurate results. For instance, we observed performance results being measured by stopwatch. Performance monitoring was based on how many and how often employees reported slow performance to the help desk. However, some employees we interviewed stated that slow response times were not always reported to the help desk.

In response to this interim finding, VA CoreFLS managers reported that performance measurements in Build 1.2 were taken with stopwatches because the project team did not have instrumentation set up on the host servers to track performance. During Build 1.3, Oracle Forms Runtime Diagnostics was used for selected test users.

However, our review of the Oracle Forms Runtime Diagnostics documentation found that the number of events logged was not sufficient to determine if system performance was acceptable. For example, on December 9, 2003, events for nine users were logged. In our opinion, events for nine users do not simulate peak demand over the Wide Area Network and should not be used to determine if the 8-second end-to-end response time was achieved.

CoreFLS Has Yet to Successfully Interface With All Other VA Medical Center Systems

Our Interim Report pointed out that CoreFLS management had not successfully interfaced CoreFLS with all other medical center systems. For example, on three occasions we identified transactions input into the VistA and the PAID systems that did not update the appropriate CoreFLS accounts. In one instance, we observed a transaction that was double-posted to the general ledger.

The JFMIP's "Federal Financial Management System Requirements" states 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.

In response to this interim finding, VA CoreFLS managers reported that users have reported occasional problems with some VistA interfaces and these problems have been

or were being addressed. Also, there were no known problems with interfacing the PAID system.

Our review of management's CoreFLS Issue and Risk Tracking System disclosed 16 open interface-related issues. As of May 3, 2004, 2 of the 16 issues concerned the VistA interface and another 2 issues concerned the PAID interface. For example, CoreFLS is unable to accept PAID cancelled check files and CoreFLS is unable to accept VistA Central Fee cancelled fee confirmation files. The remaining 12 interface issues concerned accounts payable, general ledger, budget, and miscellaneous items.

Fiscal Services Could Not Reconcile Accounts

We contacted the BPVAMC Chief, Fiscal Service to determine whether CoreFLS development issues have been adversely effecting fiscal operations. The Chief, Fiscal Service informed us that they did not have guidance relevant to CoreFLS for their monthly reconciliations. The Chief, Fiscal Service stated that although they were told with an integrated system some of the reconciliation should not be required (supply fund inventory, real property, equipment), as of May 2004, they are still required. The Chief, Fiscal Service believed it important to accomplish reconciliation as a means to determine stability and reliability of system information. We found the following issues still warrant management attention:

Accounts Payable – The Chief, Fiscal Service informed us that system data issues have not allowed for an accurate accounts payable report. Several fixes are proposed for input. BPVAMC is hopeful they may be able to accomplish the reconciliation by the end of June 2004.

Accounts Receivable – Fiscal Service is waiting for the VistA accounts receivable non-Medical Care Collection Fund (MCCF) report to reconcile those debts that are transferred to CoreFLS in detail. As of May 26, 2004, they have not been able to obtain the report. We learned that Fiscal Service has been verifying the VistA accounts receivable MCCF data collection report balance to the CoreFLS GL accounts since December 2003. The Chief, Fiscal Service informed us that the CoreFLS (non-VistA) accounts receivable subledger balances were verified in March 2004 to validate that this report was collecting data. However, the Chief, Fiscal Service acknowledged that a monthly reconciliation has not been accomplished primarily due to other CoreFLS issues they are dealing with at this time. Fiscal Service intends to begin monthly accounts receivable reconciliation effective with the May report (i.e., June 2004).

Undelivered Orders – The Chief, Fiscal Service informed us that they have not been able to reconcile undelivered orders because they are not able to secure an accurate report. Fiscal Service has set a target date to begin their reconciliation in July 2004.

Real Property – The Chief, Fiscal Service acknowledged that they do not know how to reconcile real property accounts. We were informed that Maximo does not account for real property in a manner consistent with the real property Oracle GL accounts. Fiscal Service does receive the old FMS F52 report, which showed that all fixed asset General Ledger (GL) accounts are in balance.

General Post Funds – The Chief, Fiscal Service informed us that prior to CoreFLS, fiscal employees reconciled the IFCAP running balance with FMS. However, in CoreFLS there is no record to reconcile. Fiscal Service does produce a CoreFLS report which provides the activity and balances for each General Post Fund (GPF) account according to Oracle data. Prior to IFCAP, Fiscal Service kept a paper accounting and reconciled the GL to their cards. The Chief, Fiscal Service informed us they can no longer produce a paper record with CoreFLS because Fiscal Service employees are not involved in the obligation process. Therefore, they do not see documents in order to keep a detailed accounting. Rather, the Voluntary Service tracks general post fund activity in Microsoft Excel. Fiscal Service employees obtain the Voluntary Service spreadsheet and they attempt to reconcile accounts. However, they cannot attest to the accuracy of the spreadsheet.

Patients Funds – The Chief, Fiscal Service informed us that this reconciliation has been accomplished without interruption.

Supply Fund Inventory – The Chief, Fiscal Service informed us they have reconciled accounts through February 2004, and are continuing their effort to account for all procurements.

On October 2, 2003, we reported to the Assistant Secretary for Management and the 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 an incomplete and untested service contingency plan, 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 BPVAMC on October 6, 2003, without mitigating these risks. We therefore asked the Chief, Fiscal Service whether actions to initiate parallel CoreFLS and FMS processing systems would be a viable alternative until such time CoreFLS issues could be resolved. The BPVAMC Chief, Fiscal Service informed us that in her opinion reverting back to FMS, "... would create a new set of issues for us to deal with, although given the alternative of continuing with CoreFLS versus FMS that may very well be the lesser evil."

The Chief, Fiscal Service acknowledged that since October 2003, BPVAMC continues to identify new issues, does not have reliable reports, and faces significant issues with workflow. For example, the Chief, Fiscal Service informed us that current business practices do not have Fiscal employees involved in reviewing accounting data prior to

obligation nor do they obligate funds. Fiscal employees continue to have difficulty in following transactions through the system. The Chief, Fiscal Service informed us that without Fiscal Service employees being involved in the obligation process, BPVAMC is at risk for having delinquent obligations that are not following the proper process for ratification. There is a risk for having erroneous Cost Center and Budget Object Code assignments on procurements. In addition, there is an increased risk for having erroneous Appropriation/ Fund Control Point (FCP) charges. In essence, CoreFLS has removed the traditional separation of duties, and checks and balances, between A&MMS and Fiscal Services procurement and obligation processes.

The Chief, Fiscal Service informed us that after 8 months, BPVAMC is far from stabilizing at pre-CoreFLS levels of production. The Chief, Fiscal Service was not sure how the facility could run dual systems "...given the business process/work flow changes that have come with CoreFLS, as it would be extremely difficult to manage." The Chief, Fiscal Service believed running dual systems would require additional staffing, however, the extent of the needed resources was not known.

The VA Secretary has directed a technical review which is currently being conducted by the Carnegie Mellon group to determine whether the implementation of the CoreFLS system remains a viable option for the department in integrating its financial management and acquisition systems. The success of this program is highly dependent on the accuracy and reliability of existing VA legacy systems and applications. Many facilities nationwide have not demonstrated that GIP systems are adequately in place which is discussed further in Issue 6. This was a major problem in the deployment of CoreFLS at BPVAMC. VA leadership needs to ensure all facilities have certified the accuracy and reliability of their existing VA acquisition and fiscal systems to enable the CoreFLS system to be successful. Given the results of this report and the Carnegie Mellon report, VA leadership needs to consider whether to continue CoreFLS efforts or seek other alternatives.

Recommended Improvement Action(s) 16. The Assistant Secretary for Management needs to:

- a. Ensure all facilities have certified the reliability of their existing legacy systems, and accuracy of the data, to ensure conversion problems encountered at BPVAMC will not reoccur at other sites.
- b. Strengthen data conversion procedures and tests to provide reasonable assurance that converted data will provide desired results and require certification of implementation.
- c. Ensure all CoreFLS users are adequately trained to test, operate, and maintain the system.

- d. Develop and implement a process to address findings and recommendations reported by Access Systems in the September 2003 CoreFLS Build 1.2 Quality Assurance Independent Verification and Validation Report, the April 2003 CoreFLS Build 1.2 Quality Assurance Independent Verification and Validation Test Results, and the August 2003 CoreFLS Certification and Accreditation Independent Security Test and Evaluation Report.
- e. Ensure the Independent Verification and Validation process is independently funded and reports to a VA organization outside the Assistant Secretary for Management.
- f. Segregate the duties of developing tests, executing tests, and determining test results.
- g. Develop and implement a performance measurement process that will provide VA with an accurate measure of end-to-end response times and delays.
- h. Develop and implement procedures to test system interfaces and validate results to ensure data moves effectively among all applicable systems.
- i. Resolve all fiscal reconciliation issues and ensure there are adequate checks and balances between A&MMS acquisition and Fiscal Service obligation processes.

Assistant Secretary for Management's Comments:

The Acting Assistant Secretary for Management concurred with the recommendations and provided acceptable implementation plans. Details of this response are shown in Appendix H, pages 167-174.

Office of Inspector General Comments:

The Acting Assistant Secretary for Management's comments and implementation plans met the intent of the recommendations. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Issue 5: CoreFLS Security Controls

Findings

Although CoreFLS managers have made progress in correcting weaknesses since our Interim Report, VA continues to confront significant vulnerabilities. As discussed in the Interim Report, employee duties and responsibilities need to be segregated and access controls need to be strengthened. CoreFLS 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. Many of these vulnerabilities occurred because of decisions made by CoreFLS managers. As a result, system security weaknesses put programs and data at risk of inadvertent or deliberate misuse.

Duties and Responsibilities of CoreFLS Administrators Were Not Segregated

Our Interim Report noted that CoreFLS managers needed to adequately separate the key duties and responsibilities of BearingPoint employees who had application developer, system administrator, and security administrator rights. For example, as of February 2004, five BearingPoint employees had both application developer and system administrator rights and two others had both system administrator and security administrator rights. CoreFLS managers told us duties were not segregated because BearingPoint employees needed full access to deploy the system. Because they have full access, each of these seven BearingPoint employees could create, process, and erase the transactions.

OMB Circular A-123 states that key duties and responsibilities in authorizing, processing, recording, and reviewing official agency transactions should be separated among individuals. National Institute of Standards and Technology (NIST) Special Publication 800-12, *An Introduction to Computer Security: The NIST Handbook*, dated October 1995, states that separation of duties is the division of roles and responsibilities so that a single individual cannot subvert a critical process.

In response to this interim finding, CoreFLS managers told us that application developer rights had been removed from all BearingPoint employees. In addition, CoreFLS managers stated that they were not concerned with segregating duties because they could detect improper use through the use of audit trails.

We believe CoreFLS managers have made progress by removing application developer rights from BearingPoint employees. However, we disagree with their opinion on the impracticality of segregating duties. We identified several sources that mandate segregation of duties. VA Directive 0070, *Management Accountability and Access Control*, prescribes that VA managers will provide reasonable assurance that assets are safeguarded against waste, loss, unauthorized use, and misappropriation. The Federal

Information System Controls Audit Manual (FISCAM), published by the General Accounting Office, states that information system management, systems design, application programming, systems programming, quality assurance and testing, library management and change management, computer operations, production control and scheduling, data security, data administration, and network administration should be generally performed by different individuals.

Also, our review disclosed that detection of improper use may not be possible. For example, system administrator rights allow individuals to disable audit trails and purge audit information from the database.

Managers Did Not Assign Employees Access to CoreFLS Programs Consistent With Their Roles and Responsibilities

Our Interim Report pointed out that CoreFLS managers needed to strengthen CoreFLS access controls to prevent deliberate misuse, fraudulent use, improper disclosure, or destruction of data. For instance, during our October 2003 visit, we observed and were informed by VAMC employees that CoreFLS managers did not assign employees access consistent with their designated roles and responsibilities.

OMB Circular A-130, *Management of Federal Information Resources*, requires that program managers establish controls for determining which staff, at what levels, should have access to major application systems. 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.

In response to this interim finding, CoreFLS managers stated that revised roles, responsibilities and procedures had been recently completed and posted on the CoreFLS website. The revised procedures identify users, map users to roles, review and approve users, and provide for ongoing maintenance of assigning access roles and responsibilities.

However, in our opinion, the revised roles and responsibilities procedures continue to need VA CoreFLS managers' attention. The revised procedures do not define all types of access. For example, procedures did not identify what records the Chief of Purchasing could create, read, update, and delete. Procedures did not always demonstrate the association of employee roles and responsibilities with appropriate forms and tables. For instance, the Accounts Receivable Station Super User role description states the user is the system administrator for the accounts receivable application and has access to certain configuration screens and operational functions required at the station level. Procedures did not differentiate between routine access requests and non-routine requests. For example, occasionally there will be a need to grant temporary access privileges to an individual who is not usually authorized access. The system roles procedures consisted

of a two-page high-level overview and a *CoreFLS System Roles Workshop* Microsoft PowerPoint presentation dated February 2004.

Additionally, the review and approval section in the revised procedures needs attention. On March 3, 2004, we submitted a user access request for an OIG auditor to obtain rights to the e-training application. Instead of receiving access to the e-training application, the auditor received access to the general ledger, purchasing, accounts receivable, fixed assets, accounts payable, budgeting, and suspense production applications. This oversight occurred because BearingPoint employees processed the request with a batch of production access requests and did not realize it was a training request.

CoreFLS Managers Did Not Have an Effective Contingency Plan to Protect Assets and Functionality

In our Interim Report, we noted that VA CoreFLS managers may not be able to recover CoreFLS operational capability in a timely, orderly manner or perform essential functions during an emergency or other event that may disrupt normal operations. This situation may result from incomplete contingency planning. For example, the plan does not contain sufficiently detailed guidance on roles, responsibilities, teams, and procedures associated with restoring the system following a disruption or disaster. Also, 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.

OMB Circular A-130, Appendix III states that 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.

In response to this interim finding, VA CoreFLS managers commented that because the CoreFLS deployment to date was an operational test, they deemed it unwise to expend the resources for a fully detailed contingency plan. In their opinion, the perceived benefits during the Operational Test Phase 1 measured against the costs would not justify implementation at that point.

They also commented that the first phase of the contingency plan strategy would be complete at the end of May 2004. This phase includes conducting a business impact analysis, establishing an emergency response and crisis communication plan, and completing testing of disaster recovery procedures. The second phase of the contingency plan strategy includes identification of strategic alternatives, completion of the business continuity and business resumption plan, and integration of the final plan with the VA

Continuity of Operations Plan. A completion date for the second phase was not provided in the response.

We believe effective contingency planning, execution, and testing are essential to mitigate the risk of system unavailability. As of May 2004, CoreFLS processed transactions that affected VA operations and was vulnerable to a variety of disruptions ranging from short term power loss and hardware failure to major equipment or facility destruction.

Accountability Controls Needed Strengthening

Our Interim Report noted that CoreFLS managers needed to add sufficient safeguards (audit trails) to monitor CoreFLS. As of February 2004, 60 contract employees had access rights to the production application. We believe the risk is high because CoreFLS managers have not implemented procedures for reviewing and monitoring audit logs to detect patterns of access that would indicate problems.

NIST Special Publication 800-12, *Introduction to Computer Security: The NIST Handbook*, provides guidance related to 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.

In response to this interim finding, CoreFLS managers commented that audit trail reports for 19 Oracle tables are configured in addition to standard sign-on logging and reporting. In the short term, a set of simple queries that captures changes to the audited tables is sent to a CoreFLS project team member. CoreFLS managers said that full audit logging capability has been approved for development and will be in place by mid-May 2004.

Based on our review of the CoreFLS audit trail plan and monitoring strategy dated April 30, 2004, we concluded that progress had been made. However, we believe risk remains high due to the lack of application-level audit trail reports and monitoring procedures for both technical-level and application-level audit trails. Also, we believe risks are high due to non-VA users having system administrator rights. System administrators can purge the audit trail mirror database and delete production data. Action should be taken to certify that planned changes have been completed.

Controls Over Changes to CoreFLS Software Needed Improvement

Our Interim Report pointed out that CoreFLS managers did not follow the internal Configuration Control Board (CCB) procedures governing the authorization of software changes. Specifically, our review showed that CoreFLS managers did not obtain the necessary authorizations to make software changes as required by the “CCB Charter and Procedures” document dated April 11, 2002. 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 was no assurance that the implementation of 89 software extensions and approximately 630 other major modifications during the system development life cycle were appropriate. There were also no assurances that all of these extensions and other modifications have been sufficiently documented and tracked to permit upgrades when there are new releases of the baseline software.

The FISCAM 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 are carefully controlled. VA CoreFLS procedures require approval from the CCB, which includes representatives from VHA, VBA, NCA, and the OMB, for change requests exceeding \$100,000 for baseline code and technical environment changes.

In response to this interim finding, CoreFLS managers commented that configuration change requests were submitted to the CoreFLS Executive Committee in accordance with the approved CCB charter and procedures. If changes did not require the CoreFLS Executive Committee approval, an internal CoreFLS Project Office Configuration Control Board reviewed and approved all code migration and configuration changes. CoreFLS managers also reported that Concurrent Versions Systems (CVS) was used for version control of delivery documents, build code, and program management office documents.

We do not believe the use of the CoreFLS Executive Committee is the proper compensating control for obtaining control over software changes. Our review of the CoreFLS Project Charter found that CoreFLS Executive Committee responsibilities did not include authorizing, testing, and approving program modifications. Also, our review of CoreFLS Executive Committee meeting minutes for June and July 2003, and for February and April 2004 found that technical discussions related to the modification of application software did not occur.

When we discussed software issues with the Acting Chief Technical Officer for the Office of Information Technology we were informed that his office had no involvement in the CoreFLS software approval process. Further review showed that JFMIP passed Oracle E-Business on September 10, 2003. However, we were not able to find an approval for the bolt-on applications for Maximo and DynaMed.

As of April 22, 2004, Access Systems reported that CVS was used ineffectively and contained only 34 percent of the required documentation. Based on the Access Systems report, there may be a significant control weakness over the documentation of application changes.

Recommended Improvement Action(s) 17. The Assistant Secretary for Information and Technology should ensure that the CoreFLS Project Director improves CoreFLS security controls by:

- a. Reducing production access privileges to ensure proper segregation of application developer, system administrator, and security administrator duties.
- b. Fully developing and testing procedures to ensure roles and responsibilities are assigned to users based on access criteria.
- c. Developing a contingency plan in accordance with NIST 800-34 and ensuring that testing is conducted on contingency related items to ensure continuity of operations in the event of a disruption of service.
- d. Developing and implementing procedures to monitor and log high-risk user activity and log user access.
- e. Implementing CCB procedures to help ensure program modifications are properly authorized, tested, and approved.
- f. Identifying and reviewing all prior changes made by contractors with incompatible duties to ensure the integrity of codes, configurations, and data.
- g. Documenting the software extensions and other major modifications to track the applicability of these changes to any new releases of the baseline software.
- h. Ensure software issues are reviewed and comply with all applicable technical requirements.

Assistant Secretary for Information and Technology’s Comment:

The Assistant Secretary for Information and Technology concurred with the recommendations and provided acceptable implementation plans. Details of this response are shown in Appendix I, pages 177-179.

Office of Inspector General Comments:

The Assistant Secretary for Information and Technology’s comments and implementation plans met the intent of the recommendation. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Issue 6: Management of Supply, Processing, and Distribution Activities

Findings

The SPD Section was not managed effectively, efficiently, or in compliance with VA requirements. As previously reported in our March 19, 2004, Interim Report, senior managers canceled surgeries because critical surgical supplies and instruments were not consistently available from or properly sterilized by SPD, and Medical Center managers did not correct SPD deficiencies identified by the OA&MM, the OIG, and medical center internal reviews.

Our review found that:

- Supervision and management of SPD was not effective.
- SPD policies and procedures were not documented.
- SPD inventories were not secure.
- Required annual inventories were not conducted.
- SPD staff were not trained in the use of GIP.
- GIP was not used to manage inventories as mandated by VHA.
- Conversion data was inaccurate.

As a result, supply outages and soiled instruments interrupted patient care, patients were placed at risk, and full deployment of CoreFLS was delayed.

Background

SPD's primary mission is to properly manage and distribute medical supplies so that professional medical staff can concentrate on direct patient care with the assurance that needed supplies will be available. A vital component of patient care, SPD is responsible for the receipt, storage, and distribution of medical supplies, and the decontamination and sterilization of reusable medical supplies and equipment. Until February 2004, when it was reorganized under Nursing Service, the medical center SPD Section was an administrative function under the Materiel Management Division of A&MMS. SPD consisted of the Office of the Chief and four units—Preparation and Decontamination, Distribution, Inventory Management, and Evening.

As of June 2004, the SPD Section was under the temporary supervision of the Chief, SPD, from the Haley VAMC. The AD³⁸ and Chief, A&MMS, were responsible for the management of SPD. The approved staffing ceiling in SPD was 42 FTE. As of

³⁸ The AD was responsible for developing systems to monitor available resources, including personnel, space, equipment, and funding, and for establishing priorities for distributing these resources based on program needs.

March 18, 2004, staffing consisted of 34 FTE. SPD expenditures for medical supplies in FY 2004 through April 28, 2004, were about \$3.3 million. FY 2003 expenditures were \$3.2 million. As of April 6, 2004, the reported value of SPD inventories in CoreFLS was about \$1.6 million.

We reviewed the inventory management practices of the SPD Section as part of our evaluation of clinical and administrative management issues at the medical center. The purpose of our review was to determine whether SPD was operating effectively and efficiently. Accordingly, our objectives were to determine whether medical center inventories of medical supplies were adequate to support patient care, inventories were managed in accordance with VA requirements, the management of medical center inventories impacted the implementation of CoreFLS, and the implementation of CoreFLS affected the availability of medical supplies.

Supervision and Management of SPD Operations Was Not Effective

A&MMS and Nursing Service managers told us that the operating efficiency in SPD began to decline in 2001 when the Chief, SPD, was promoted to Chief, Materiel Management Division. The former Chief maintained an office in the SPD administrative office suite and continued to supervise the section, even after a new Chief, SPD was appointed on July 29, 2001. Documents showed the Chief, Materiel Management Division retired on January 3, 2002.

According to SPD staff, the new Chief, SPD, was not effective as a supervisor, and was subsequently reassigned to a position as a Supply Systems Analyst at BPVAMC on January 25, 2004. As of June 2004, the Chief, SPD, at the Haley VAMC, was temporarily acting as Chief, SPD. At the time of our review, SPD was operating 8 FTE below its authorized ceiling, which contributed to problems in SPD.

SPD went without competent supervision for over 2 years and during the same period, the supervisors of the Preparation and Decontamination Unit and the Evening Unit, and a senior technician in the Preparation and Decontamination Unit retired. In our opinion, the loss in technical expertise, the 2-year void in leadership and under-staffing contributed to conditions that were harmful or potentially harmful to patients.

Senior managers bear substantial responsibility for not providing vigorous leadership to mitigate these problems. For example, the AD did not ensure the correction of previously identified deficiencies in SPD. In January 2001, the OA&MM reported numerous deficiencies in SPD concerning inventory management and sterilization practices to senior managers.

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 by the sterilizer technicians, 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 OR.
- Expired sterile items were found on shelves in the SPD clean/sterile storage area.
- 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 GIP was not used properly.
- SPD and warehouse storage areas were not secure.
- Staff was not adequately trained.

In January 2003, the OIG CAP review reported to senior managers that crash carts did not always contain essential supplies and equipment necessary to perform life support procedures, medical instruments were not properly sterilized, and inventory controls needed strengthening. Management resisted concurring in the OIG recommendation to improve controls and accountability for crash cart replenishment. While eventually concurring in the recommendation, the condition continued to exist. Investigation of the crash cart issues did not substantiate that SPD personnel were intentionally sabotaging surgical carts. It did, however, disclose non-compliance with VA requirements. In September 2003, BPVAMC internal reviews of SPD cited problems involving improperly stocked case carts, unsterilized instruments, inadequate inventory levels, and a lack of focus by SPD staff. Similar problems were identified by another internal review of SPD in January 2004. Despite these repeat findings presented to SPD managers and to the AD (Acting Director at the time of the OIG CAP review), similar problems continued to exist.

During our most recent review of SPD activities, we found that senior leadership had not ensured suitable site preparation for the conversion to CoreFLS. In spite of repeated notices by VHA of the need for an efficient inventory management program, the medical center inventory management processes and procedures were severely deficient. Since

October 2002, VHA released annual updates of VHA Handbook 1761.2 notifying VHA field stations of VA's impending change to CoreFLS, and requiring the use of the GIP and its successor system (CoreFLS) to manage VHA inventories.

Each update:

- Underscored the necessity of having both a properly trained inventory management staff, as well as an inventory management program that ensured databases were populated with consistent and accurate data.
- Stressed the importance of avoiding the over-stocking and under-stocking of supplies. Facilities were reminded that over-stocking ties up resources in stock that may become damaged or outdated; under-stocking creates the risk of unavailability of supplies, which affects the quality of patient care, and also creates additional purchase costs (overnight shipping) and adversely affects the trust users have in logistics staff.
- Emphasized that experiences at many VA facilities had shown there were fewer stock outages, better inventory controls, reduced inventories and costs, and fewer emergency procurements by using GIP.

Despite VHA's notices, senior managers did not take sufficient actions to reduce the risk of adverse outcomes. For example, patient care was adversely affected (canceled surgeries) because of stock outages and soiled instruments, and SPD was reorganized under the supervision of Nursing Service after patient care staff lost trust in logistics staff. To illustrate, we reviewed three post-arthroscopic wound infections that occurred in a 9-month period. We found that two of these infections were caused by gram negative organisms – a type of bacteria that is unusual for infections of this nature in that location. Although we could not prove that these infections were the result of contaminated instrumentation, their timing and the species of bacteria cultured raise this possibility. At a minimum, this highlights the seriousness of the overall concern about the provision of sterile equipment from SPD to the OR.

We also found that resources were tied up in excess inventories, unnecessary overnight shipping costs were incurred, and the conversion to CoreFLS was disrupted because management did not follow policy, and did not ensure that inventory management staff were trained as required, or that inventory management systems contained consistent and accurate data. The following illustrates the problems identified during our most recent visits to the BPVAMC.

SPD Policies and Procedures Were Not Documented

The policies and procedures template contained in SPD Handbook H 90-1 had not been completed in accordance with VHA requirements. SPD management had not filled in the

blanks in the template relating to operational procedures (i.e., there was no organizational chart, no references to SPD operating hours, and no identification of SPD employees and their duties).

There were no floor plans indicating work-flow, and there were no documented local operating procedures, such as procedures defining how stock should be issued after hours, methods for replenishing and maintaining secondary stock locations, personnel to be contacted in case of emergencies, or equipment operating instructions. There were no indications that the Chief, A&MMS, the Chief, SPD, or SPD supervisors had read the SPD Handbook because of the numerous blanks. In our opinion, the adverse impact of staff attrition may have been minimized or avoided if SPD policies and procedures had been documented and staff had been trained.

SPD Inventories Were Not Secured

Security of inventories was made ineffective by uncontrolled access to the SPD stockroom and unsecured surgical case carts. For example, the entrances to the SPD stockroom were not controlled, and unauthorized staff frequently removed items from the inventory with no adjustments to the inventory records. VHA policy requires that SPD stockrooms are physically secured, and that unauthorized personnel entering SPD's stockroom be accompanied by an appropriate SPD supervisor or designee. Our review found that the SPD stockroom was not physically secured. SPD staff told us that unauthorized personnel routinely traveled through SPD while going to and from the main hospital. SPD staff stated that they were never told that access should have been restricted to authorized personnel. Without controlled access, there is no way to ensure security of supplies or maintain inventory control. According to SPD and Nursing Service staff, Surgical Service staff frequently went to the SPD stockroom and removed needed supply items because they could not depend on SPD to distribute supplies to Surgical Service. This was not consistent with SPD's primary goal of effectively managing inventories to allow professional medical staff to concentrate on direct patient care.

Surgical case carts were not secured by locking mechanisms. Once the carts were filled, there was no way to prevent individuals from removing items from them. Further, staff responsible for filling the carts were not identified or held accountable for the contents.

Required Inventories Were Not Conducted

SPD had not conducted annual wall-to-wall or cyclical (not all at one time) supply inventories as required by VA policy. VA policy requires annual wall-to-wall or cyclical inventories that include all items annually. According to medical center staff, the last inventory was taken about 3 years ago. A February 2004 inventory improvement plan prepared by BPVAMC staff and Bearing Point showed that a physical inventory was

scheduled for March 29, 2004; however, the inventory was not conducted. A revised improvement plan, dated March 15, 2004, showed that the physical inventory was rescheduled for May 8, 2004. Medical center managers stated that the inventory had not been conducted because other planned changes that affect the quantities on hand, such as improved security and staff increases, had not been made. An April 5, 2004, plan showed that a physical inventory is not scheduled until June 30, 2004.

SPD Staff Were Not Trained in the Use of GIP

Our Interim Report pointed out that BPVAMC employees were not adequately trained in the use of CoreFLS. Subsequent review showed that inventory management employees were also not properly trained in the use of GIP, which indicated that inadequately trained inventory management staff was a chronic problem at this medical center. VHA policy requires that inventory management staff be trained in the use of automated inventory management systems. VHA delegated to the Chief, A&MMS, the responsibility for providing facility logistics staff with the education and training necessary to optimize VA's investment in supply inventories. To meet this objective, VHA mandated the following training programs to train BPVAMC inventory management staff in the use of automated inventory systems:

- The VHA Logistics Office and the OA&MM's "Train the Trainer Program" was designed to train selected staff from each VISN in basic inventory management practices and small purchasing regulations (up to \$25,000), and the use of GIP so that they could return to their VISNs and train others.
- VISN-level training required training teams from the "Train the Trainer Program" to conduct training programs for inventory staff throughout the VISN. This training was to be completed within 60 days after completion of the train-the-trainer sessions, and records of the completed training were to be forwarded to the VISN Chief Logistics Officer (CLO). This VISN-level training occurred in March 2002.
- Facility-level training required facility inventory management staff at the facility to educate users on the inventory management process.

The Chief, A&MMS, told us that medical center staff had not participated in the "Train the Trainer Program," or attended the VISN-level training. However, the VISN CLO provided documentation showing that the prior Chief, SPD, had attended a 1-day training session on the implementation of GIP, the use of GIP reports, and strategies for managing inventory.³⁹

³⁹ The prior Chief, SPD, was reassigned to another position in A&MMS in January 2004.

The Chief, A&MMS, stated that the medical center did have two employees in SPD who were generally considered experts in the use of GIP. One of these employees had transferred to another facility before our visit. The other employee told us that he had received no formal training in the use of GIP, and that he had acquired all his knowledge of GIP operations on his own time and initiative. We interviewed three other employees either currently assigned to SPD, or assigned to SPD after the VA mandate to use automated inventory systems. All three employees stated that they had not received any GIP training.

Medical center managers did not ensure that SPD employees were properly trained to perform inventory management tasks, which were critical to the mission of the medical center and SPD operations.

GIP Was Not Used to Manage Inventories as Mandated by VHA

VHA policy mandated the use of GIP or its successor system for the management of all supply inventories.⁴⁰ The DynaMed module of CoreFLS is the successor system to GIP. Like GIP, DynaMed is capable of maintaining stock levels and reorder points; identifying supplies that need to be ordered; interfacing with bar code technology to facilitate the identification and costing of inventory items; and generating reports relative to inactive items, usage and demand, issues, receipts, and adjustments.

However, DynaMed combines the capabilities of IFCAP⁴¹ and GIP into one application. DynaMed automatically generates order requisitions and routes them to a Requisition Pool in Oracle,⁴² providing an integrated approach to logistics and financial management.

The GIP application was installed in SPD, but it was not used to maintain SPD stock levels and reorder points. We found the use of bar code technology was hindered by inoperable scanners and inventory locations that were not labeled. SPD staff acknowledged they used rudimentary manual procedures to manage SPD inventories, and IFCAP, GIP, and FMS never contained current and accurate data, such as inventory levels, usage histories, and vendor information. Consequently, CoreFLS DynaMed was populated with inaccurate data.

Conversion Data Was Inaccurate

The CoreFLS Site Preparation Plan required IFCAP, GIP, and FMS data be converted to CoreFLS. The plan allowed 6 months before the October 6, 2003, activation date for the

⁴⁰ VHA Handbook 1761.2.

⁴¹ Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement (IFCAP).

⁴² Oracle is the CoreFLS module used to manage accounting, budgeting, contracting, and purchasing. The Requisition Pool is an area where medical center requisitions are accumulated until a purchasing agent assigns a PO number and places the orders. The Requisition Pool facilitates multiple acquisitions from the same vendor.

medical center to “cleanse” the data in the legacy systems for conversion purposes. However, BPVAMC managers did not ensure data cleansing efforts were completed in time to meet the CoreFLS activation date. VA proceeded with the deployment of CoreFLS despite the fact that the conversion data had not been properly “cleansed.”

GIP Data Was Inaccurate. The data in GIP was inaccurate and unreliable because SPD had not used GIP to manage inventories. Because SPD managers did not routinely review the GIP database, GIP contained about 10,000 supply items, approximately 50 percent of which were duplicate items. GIP also contained some items that did not have specified item locations. Approximately 5,000 of the initial 10,000 items were removed from GIP before CoreFLS was activated because they were duplicate items.

Approximately 2,500 of the remaining 5,000 items had no inventory activity during the 13 months preceding activation, and would not be automatically transferred to DynaMed based on the conversion rules. Because SPD management had no confidence in the GIP data and did not want to take the chance that some of these items might be needed later, staff entered fictitious inventory activity for these items in GIP, such as internal stockroom transfers and location changes, so they would be transferred to DynaMed. As of April 21, 2004, DynaMed records showed about 3,300 items valued at about \$117,000 in the SPD inventory that had no activity since CoreFLS was activated.

IFCAP Data Was Incomplete. An additional 1,584 high-use items were transferred to DynaMed from the IFCAP Item Master File (IMF) because they were not maintained in GIP. As a result, these items had no usage history, resource objective,⁴³ or reorder point. After CoreFLS was activated, it was discovered that the 1,584 high-use items had missing or incorrect vendor names, addresses, or product numbers. As a result, the Oracle module of CoreFLS suspended the requisition of these items and interrupted the flow of needed supplies to the OR.

Vendor Data Transferred From FMS Was Incomplete. Vendor sourcing information transferred from FMS to Oracle also did not consistently specify vendor names, part numbers, or contact information, such as telephone numbers and payment addresses. VA CoreFLS staff told us that problems with vendor data occurred because medical center staff did not follow correct procedures when they used vendors that were not in the IFCAP IMF. Under the IFCAP system, when placing orders, users could choose a vendor from the IFCAP IMF. If the user required a vendor that was not included in the IMF, the correct procedure was to notify IMF staff so that the new vendor could be added to the IMF. This action would have updated the vendor file in FMS. Instead, medical center staff used a free text option in IFCAP to input the vendors’ information on their purchase orders (PO). However, since text fields were not transferred during IFCAP/FMS interfaces, IFCAP did not completely update vendor files in FMS. In some

⁴³ The maximum quantity that should be carried in inventory.

cases, vendors' names were missing and in other cases there were improper matches in part numbers and contact information.

When CoreFLS was activated, it did not function as project managers expected because of inaccurate or incomplete vendor and IFCAP/GIP data. Because of incomplete vendor data, Oracle suspended requisitions for the 1,584 high-use items mentioned earlier in this report, and employees bypassed DynaMed and Oracle to purchase these items. SPD staff told us that they were unaware that the requisitioned transactions had been suspended and that they did not know they were supposed to review the Oracle Requisition Pool within a prescribed time frame. As of April 9, 2004, the BPVAMC still had not corrected the vendor data for 352 of these high-use items.

Additionally, because BPVAMC employees did not completely cleanse the GIP data file, properly setting the resource objectives and reorder points, requisitions were automatically generated for unneeded items. When DynaMed auto-generates a requisition, the approving official has 24 hours to disapprove the transaction, or it is automatically sent to the Oracle Requisition Pool for procurement action. As a result, unneeded items were procured because approving officials did not timely review the requisitions to ensure that the items were truly needed. These events caused critical stock outages of some highly used medical supplies and excessive purchasing and overstocking of other items.

Impact of Erroneous Conversion Data on SPD Operations

The Chief, A&MMS, and Nursing Service managers told us that Nursing Service lost confidence in SPD after surgical case carts were repeatedly delivered to the OR with missing items and instruments that were not sterilized. The adverse effect of the unavailability of medical supplies on patient care received significant attention by the local media, Congress, and the OIG. As a result of these problems, on February 28, 2004, SPD was reorganized under Nursing Service. The SPD Section had failed to meet its primary goal, and medical staff became involved in the inventory management process.

To ensure that adequate supplies were available, SPD staff turned off the auto-generate function of DynaMed and returned to manual inventory procedures. The Chief, A&MMS told us that he directed SPD staff to use manual procedures to ensure adequate supplies were available. Our review showed that managers, supervisors, and staff resorted to extreme procurement practices that negated the management controls over the acquisition and payment process, and left the medical center vulnerable to overpriced medical supplies.

We found the following:

- Purchases bypassed DynaMed and/or Oracle
- Excessive purchases of medical supplies
- Excessive late payment penalties
- Inaccurate inventory records

Purchases Bypassed DynaMed and/or Oracle. As the result of the intense scrutiny that resulted from the BPVAMC running out of surgical supplies, SPD employees rushed to fill SPD stock bins in early February 2004. We found that SPD employees departed from VA acquisition and payment processes and began bypassing DynaMed's requisition process and/or Oracle's purchasing procedures.

Initially, the Chief, SPD ordered supplies from vendors' telephonically using mock PO numbers.⁴⁴ To distinguish his procurements, the Chief, SPD developed a simplistic manual PO system that combined his initials with a sequential numbering scheme. Not only were these procurements not entered into DynaMed or Oracle, which caused the inventory and financial records to be understated, requisitions were not created and PO numbers were not assigned. Without PO numbers, vendors could not be paid and the medical center incurred penalties for making untimely payments.

To further expedite the acquisition and delivery process, SPD brought a local vendor representative in-house to order medical supplies. We learned that the representative was given access to the vendor files in VistA after a medical center employee had logged onto the system using the employee's access code. During the period February 1, 2004, through March 15, 2004, the representative placed orders with 36 vendors for 268 items valued at \$263,664. The representative also placed orders with his company for 32 items valued at \$62,679. Our review of past procurements for 30 of the 32 items valued at \$60,059 purchased by the representative from his company showed that the medical center previously purchased these items for only \$18,726.⁴⁵ Orders totaling \$218,333 placed by the vendor bypassed DynaMed. These items were purchased using Oracle-assigned PO numbers reserved for emergencies and included a generic item description of "medical supplies," units of issue that were recorded as "Dollars, U.S.," and the quantity field was populated with the currency amount.

⁴⁴ We were unable to determine the volume or value of supplies purchased by SPD using this practice because of inadequate documentation.

⁴⁵ The procurements from the representative's company are under further OIG review for potential overpricing of supply items that were not acquired from FSS sources. The practice of the BPVAMC and other facilities not procuring items from FSS sources was highlighted in our audit entitled, "Audit of VA Medical Center Procurement of Medical, Prosthetic, and Miscellaneous Operating Supplies", Report Number 02-01481-118, dated March 31, 2004.

On one occasion, the representative purchased supplies valued at \$179,300 from 25 different vendors using a single PO obligated for only \$5,000. This PO for multiple vendors resulted in additional late payments after the Austin Finance Center forwarded the vendors' unpaid invoices to the BPVAMC for payment. To ensure that vendors were paid, the medical center split the consolidated procurements into separate POs for each vendor, and then inappropriately used the Government Purchase Cards assigned to three supply technicians.⁴⁶

Documentation reviewed showed that the BPVAMC allowed the vendor representative to use the Government Purchase Card assigned to one supply technician to pay for supplies he ordered. The BPVAMC did not maintain detailed documentation of the quantities acquired for the generically described supplies, and was using vendor invoices and shipping documents to identify the items and quantities that had been purchased. In addition, the generic item description prevented Oracle from assigning Stock Keeping Unit (SKU) numbers⁴⁷ and prevented DynaMed from updating the inventory records. Thus, the value of SPD inventory and DynaMed Stock-On-Hand Reports were understated by unknown amounts.

Excessive Purchases of Medical Supplies. SPD expenditures for FY 2004 through April 28, 2004, totaled \$3.3 million, compared to total FY 2003 expenditures of about \$3.2 million. At this pace, FY 2004 expenditures could double the FY 2003 expenditures. These expenditures represented over 8,000 purchases from vendors and the medical center's warehouse.

The increased expenditures were, in large part, attributable to uncoordinated manual inventory management and purchasing procedures. The following examples illustrate the excess purchasing:

- 75 medical surgical items were purchased two or more times on the same day. The value of the purchases totaled \$109,207. Transactions ranged from 62 items purchased two times on the same day to three items purchased seven times on the same day.
- 61 cases of sterile wraps valued at \$2,983 were purchased between December 4, 2003, and March 3, 2004. According to SPD staff, the maximum usage of sterile wraps at the medical center was two cases per month. If historical use patterns continue, it would take BPVAMC over two years to use these supplies.

⁴⁶ Contact with medical center staff indicated there were several other occasions where procurements from numerous vendors were consolidated on a single PO. This issue is under further OIG review.

⁴⁷ The SKU number is a six-digit reference number assigned by Oracle to all inventory items to facilitate item replenishment.

- Purchases were made that were not needed. For example, six items with a total value of \$130,850 were issued to SPD from the warehouse on November 18, 2003, but were returned to the warehouse in their entirety on November 25, 2003. Overall, 355 items valued at \$348,000 were returned to the warehouse from SPD during the period October 1, 2004, to March 11, 2004. Additionally, on February 23, 2004, SPD purchased 100 cup biopsy forceps with a total value of about \$30,700, which were shipped overnight to the medical center, but returned to the vendor on March 16, 2004.
- Non-SPD items, such as stents, were requisitioned or purchased. Nursing Service staff requisitioned 912 stents on February 24, 2004, totaling \$146,500. The procurement action was stopped when we questioned why SPD was purchasing a Prosthetics item. However, from December 3, 2003, to February 23, 2004, SPD funds were used on 7 occasions to purchase 21 stents valued at about \$3,000. Stents should have been purchased from the Prosthetics fund control point.
- Overnight and 2nd-day shipping charges for purchased items totaled over \$11,800 for FY 2004 through April 28, 2004.

These examples showed that the procurement process for SPD-stocked items was erratic, and that SPD staff were operating in an emergency mode, with minimal regard for cost-containment. We inventoried some items in March 2004, such as the 61 cases of sterile wraps, and verified that they were accounted for; however, the actual stock levels in SPD inventories are largely unknown. The volume of procurement activity, in conjunction with the absence of controls and questionable acquisition practices raised serious concerns as to whether all the supplies acquired by SPD arrived at the medical center and were available for patient care. Management needs to take actions to ensure that SPD accounts for all supply items and quantities acquired by the medical center.

Excessive Late Payment Penalties

Late payment penalties by the medical center for the first 2 quarters of FY 2004 totaled \$10,800, compared to \$600 for the entire FY 2003. As of April 28, 2004, the medical center had invoices valued at about \$808,000 that were on-hold for various reasons. Some invoices were placed on-hold because the invoices could not be matched with POs (items purchased outside Oracle); checks were returned to Treasury because of a bad address or erroneous vendor information; or there were insufficient funds to pay the obligations.

Inaccurate Inventory Records

DynaMed inventory records grossly overstated the value of SPD's inventory. When we initiated our review in February 2004, DynaMed inventory records reported the value of

SPD's inventory as \$3.6 million. Our review found that the inventory was overstated by approximately \$2.3 million because an item valued at \$23, showed a quantity on-hand of 100,000, when in fact, SPD had a quantity on-hand of 1. Similar discrepancies continued to exist at the completion of our review in April 2004.

Our review of SPD disposable items valued at more than \$10,000 identified 13 items with a total value of about \$670,000, which represented 40 percent of the value of the entire SPD inventory of \$1.65 million, as of April 6, 2004. We found that the actual quantities on-hand did not agree with the recorded quantities-on-hand for any of the items. In addition, the unit prices for 7 of the 13 items (54 percent) were incorrect. The unit prices recorded in the inventory records were for "cases," but the quantities on-hand were recorded for "each." As a result, the inventory for these 13 items was overstated by about \$609,000. These unit-of-issue errors were the result of inaccurate conversion tables in Oracle and DynaMed.

The FMS, GIP, and IFCAP systems contained inaccurate data because they had not been used properly. The effect of transferring the inaccurate data in these systems to CoreFLS was damaging, and interrupted patient care and medical center operations. We are concerned that similar conversion problems will occur at other VA facilities as the system is deployed nationwide. For example, 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 staff needed to reduce medical supply inventory levels to the 30-day supply goal and monitor supply usage rates.

Corrective Actions Taken or Planned by Medical Center Management

An SPD action plan, dated April 5, 2004, showed that management had taken or planned corrective actions in areas relating to:

- Organizational Alignment – On February 28, 2004, SPD was realigned from A&MMS to Nursing Service.
- Infection Control – On February 20, 2004, an assessment of the preparation area was conducted. Management also established infection controls standards, based on the SPD handbook, and plans to implement an on-going measurement system to ensure that infection control procedures are followed.

- Security – SPD plans to improve security by using access control cards, and replacing existing case carts with locking carts. June 1, 2004, is the target completion date for both improvements.
- Physical Plant – SPD plans to physically separate case cart/OR items from distribution items by June 1, 2004, and conduct a complete physical inventory of SPD items by June 30, 2004.
- Staffing – The VISN detailed an OR nurse, Chief, SPD, and lead day/evening technician to the medical center from the Haley VAMC for 60 days. The medical center has identified a need for 11 positions, which were approved and position descriptions have been developed for high priority positions. Positions for the Chief, SPD, Evening Supervisor, Lead Weekend, and Supervisor, Preparation Unit have been posted and recruitment actions are in progress. An organizational chart with long-term needs for 24-hour coverage has been developed. Additionally, an OR Nurse Liaison position was established and temporarily filled on March 10, 2004, and staff training and competency development for SPD and OR staff are ongoing.
- Equipment – In March 2004, SPD purchased new steam traps to prevent water droplets on OR instruments, and ordered over \$200,000 of new surgical instruments. SPD also purchased new crash carts in March 2004, and established a systematic process to ensure that crash carts are properly stocked.

We did not verify management's assertions concerning the corrective actions taken, however, we agree that the planned actions are needed to improve SPD operations. Management needs to follow through and closely monitor implementation actions to ensure that the upgrades are carried out as planned. In addition, because DynaMed inventory reports were so inaccurate they are currently of no use in managing SPD's inventory. Management needs to ensure that:

- All non-essential inventory line items are removed from the SPD *Stock Room Report*.
- Surgical instrumentation that should be capitalized as equipment should be moved from the SPD medical supply inventory to an equipment inventory control point.
- All vendor file information is verified for completeness and accuracy.
- Resource objectives and reorder points for all SPD inventory line items are verified for correctness.

Management needs to ensure a wall-to-wall inventory of SPD is conducted as soon as possible, to include an item-by-item reconciliation of procurements to distributions, explanations of all significant discrepancies, and approved adjustments documented in accordance with VA policy.

Conclusion

The SPD Section at BPVAMC was not managed effectively, efficiently, or in compliance with VA requirements. Inventories of medical supplies were not adequately maintained to support patient care, supplies were not managed effectively and in accordance with VA requirements. Managers also did not ensure existing inventory data was accurate prior to deploying the CoreFLS system at the facility. Consequently, patient care was interrupted by supply outages and soiled instruments, and full deployment of CoreFLS has been significantly delayed.

Recommended Improvement Action(s) 18. The VISN Director needs to:

- a. Take appropriate administrative actions against responsible managers for not taking timely actions to preclude surgical work stoppages, inadequate site preparation for conversion to CoreFLS, and procurement disruptions and irregularities.
- b. Review the appropriateness of the contractor representative's purchases from his own firm, whether actions should be taken to seek reimbursements for any overcharges, and ensure all other purchases made from the blanket PO were appropriate and accounted for.
- c. Take appropriate administrative actions against employees that violated security password and Government Purchase Card procedures.
- d. Strengthen leadership in SPD by recruiting a proven leader as the Chief, and filling all vacancies.
- e. Develop and implement policies and procedures for managing SPD that are proactive, based on VA standards and regulations, and are made available to applicable employees.
- f. Improve security of the SPD stockroom and other inventory areas by restricting access, and obtain surgical case carts that can be adequately secured.
- g. Perform a wall-to-wall inventory of SPD and conduct annual inventories of all stock items.
- h. Ensure that mandatory inventory management systems are fully used to maintain control over inventory stock and avoid excess purchases.
- i. Ensure that SPD employees are adequately trained in the use of VA-mandated automated inventory management systems.

- j. Ensure that SPD inventory records are updated by removing all nonessential inventory line items from the SPD inventory, moving surgical instrumentation to a separate inventory control point, procuring prosthetic items from the appropriate control point, verifying all vendor file information is complete and accurate, verifying that resource objectives and reorder points are correct for all SPD inventory line items, and correcting quantity discrepancies.

VISN and BPVAMC Directors' Comments:

The VISN and BPVAMC Directors concurred with the recommendations and provided acceptable implementation plans. Details of this response are shown in Appendix G, pages 155-157.

Office of Inspector General Comments:

The VISN and BPVAMC Directors' comments and implementation plans met the intent of the recommendation. We will continue to follow-up until all actions have been taken and the issues have been resolved.

Background Leading up to Selection of the CoreFLS Integrator

CoreFLS, formerly known as IFMS, is a major system/application effort to improve VA's core financial and logistical business processes through the acquisition and implementation of a seamlessly integrated financial and logistics system. It uses COTS software, employs best practices, and is slated to be a department-wide solution. The core financial solution for this project will be a JFMIP certified financial system.

In June 1998, Booz Allen Hamilton (BAH) submitted to VA a deliverable under contract, V101(93)P-1445 Task Order 15, titled "Final Requirements Analysis for a Future Integrated Financial Management System." This deliverable outlined the required functionality and capabilities needed in order for the entire VA network to operate as a single, integrated financial management system.

Between October and December 1998, VA's IFMS Team identified VA's value added requirements for the integrated financial logistics system. The IFMS Team reduced the requirements list to the most critical requirements.

In December 1998, the IFMS Team and BAH contacted vendors asking them to submit proposals to participate in the COTS laboratories. The purpose of the laboratories was to identify COTS capabilities to support VA's value-added requirements. Vendors, SAP, Oracle, and American Management Systems, were selected to participate in the laboratories beginning January 18, 1999, and ending March 5, 1999. On March 11, 1999, BAH briefed the IFMS Team that the laboratories indicated 71 percent of VA's value-added requirements could be satisfied by COTS products.

Between March 1999 and April 1999, BAH worked with the IFMS Team to prepare items for the Capital Investment Board (CIB) application. On May 14, 1999, the CIB application (which was subsequently revised on July 28, 1999) was submitted for approval. The CIB application described VA's desire to replace the existing financial management system and selected other applications that collect and feed financial information to the core system with an integrated, department-wide, COTS-based core financial and logistics system.⁴⁸ The application described COTS vendors, agencies, and industries research in addition to identifying project schedules, project risks, and funds requirements.

⁴⁸ Capital Investment Board Application, July 28, 1999.

According to the CIB application, the project was divided into four phases for the duration of October 1998 through September 2002. The table below describes the four phases.

**CIB Proposal Application for CoreFLS
Phase Duration**

Phase	Duration
Phase I: CIB Preparation Time Frame	October 1998 – May 1999
<ul style="list-style-type: none"> • IFMS Team Established 	October 1998
<ul style="list-style-type: none"> • Identification of High-Level Requirements 	October 1998 – November 1998
<ul style="list-style-type: none"> • Scenario Development 	December 1998 – January 1999
<ul style="list-style-type: none"> • COTS Laboratory 1 	January 1999 – January 1999
<ul style="list-style-type: none"> • COTS Laboratory 2 	February 1999 – February 1999
<ul style="list-style-type: none"> • COTS Laboratory 3 	March 1999 – March 1999
<ul style="list-style-type: none"> • Submit CIB Application 	May 1999
Phase II: Acquisition Planning	May 1999 – January 2000
Phase III: Procurement Time Frame	September 1999 – September 2000
Phase IV: Implementation Time Frame	October 2000 – September 2002

In June 1999, VA contracted a new effort with BAH to prepare an approach to IT architecture for IFMS, assess enterprise resource planning vendor technical characteristics and limitations, develop a draft IFMS IT architecture, and present a final report on IFMS IT architecture.

Between June 1999 and October 1999, VA's CoreFLS Team briefed VA Administrations and OMB, and initially scheduled Business Process Workshops and developed the IFMS project plan.

In October 1999, the CoreFLS Team met with OA&MM and the Office of General Counsel to address accelerated procurement issues. It was confirmed that a Millennium-type contract vehicle could be used.⁴⁹ Millennium as defined by GSA is a Government-Wide Acquisition Contract Program consisting of nine Indefinite Delivery/Indefinite Quantity (IDIQ) contracts that are accessible to all Federal Government agencies requiring IT services. These IDIQ contracts allow the use of non-protestable task orders. The SOW was being developed and concurrence was sought from the Office of Assistant Secretary for Management.

⁴⁹ IFMS Status Report week of October 29, 1999, to November 1, 1999.

In November 1999, VA tasked BAH under CoreFLS Phases II and III to provide services which covered expert analysis supporting Business Process Reengineering (BPR), IT architecture tasks, updates to the IFMS Cost Benefit Analysis, and other CIB material.

CoreFLS Integrator's Role is Defined

Office of Financial Systems (OFS) Briefing Note states that in March 1999, the OFS obligated \$3,002,431 to the 1VA+Fund to fund Phase II, Acquisition Planning, and partial funding for Phase III, Acquisition of the IFMS project. The Integrator in support of the Core Financial and Logistics System part of IFMS was scheduled to provide services through September 30, 2000. Tasks funded were: 1) participation in 11 BPR workshops in the Washington, D.C. area; 2) provide expert advice, assistance and participation to consider commercial and Federal best practices in the areas of healthcare and hospital administration, insurance and benefits management, supply chain, logistics and procurement management, loan sales, and Federal financial management during VA BPR workshops; 3) participate in assessing VA's information technology architecture of existing VA financial systems, and participate in planning for the infrastructure necessary to support an enterprise-wide IFMS solution; and 4) participate in preparing requirements documents, evaluation and selection criteria, risk assessments, and expert technical and business advice to the IFMS program managers. On November 17, 1999, VA program officials recommended approval of \$800,000 from the 1VA+Fund for the IFMS project to proceed.⁵⁰

In order to assist in acquiring a VA integration partner, an acquisition strategy was developed using FAR 7.105.⁵¹ Evaluation factors were developed that the CoreFLS evaluation team would use to evaluate prospective integrators. The factors included inquiring whether the offeror understood VA's problems, qualifications, past performance with Federal government customers, key personnel, price, and other factors that would impact the success of the firm performing Phases II, III, and IV.

A "white paper" was published in the FedBizOpps and on OA&MM's website that provided preliminary details concerning VA's desire to obtain an integration partner for the CoreFLS project.⁵² It described the project and the selection method VA would be using to determine the integrator's qualifications. The selection would be made prior to January 1, 2000, and VA anticipated that the integrator would serve as VA's implementation partner. VA selected BearingPoint based on their proposal price of \$765,165 to accomplish Phase II. In a December 21, 1999, e-mail from the Contracting

⁵⁰ Office of Financial Systems Briefing Note, November 17, 1999.

⁵¹ Acquisition background and objectives.

⁵² White Paper Integrator IFMS, December 1, 1999.

Officer (CO) to the Deputy Assistant Secretary for Acquisition and Materiel Management, the CO stated:

- The submissions came in for the “Integrator.”
- Based on the market research all four of the firms were considered well-qualified to perform the work. The team reviewed the submissions; the deciding factor was price.
 - KPMG proposed a price of \$750,165.
 - Andersen Consulting proposed a price of \$1,457,000.
 - PricewaterhouseCoopers proposed a price of \$1,970,000.
 - Computer Sciences Corporation proposed a price of \$2,550,000.

In Issue 3 of this report, we discuss how VA’s source selection of BearingPoint for Phase II of the CoreFLS project eventually led to awarding them 22 task orders totaling \$116.5 million non-competitively.

CoreFLS Phases and Milestones

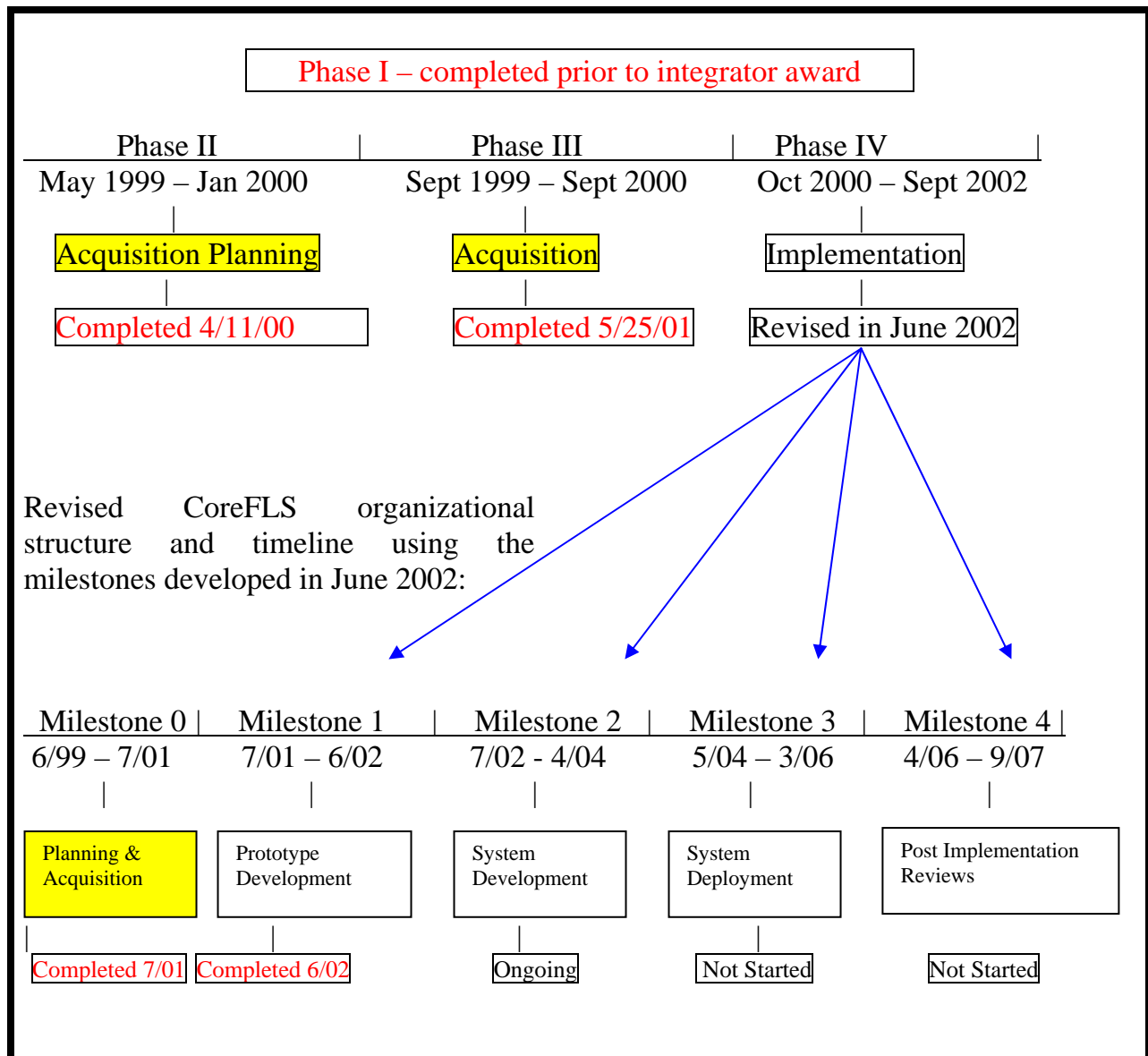
As a part of our review it became necessary to determine the operational phase the CoreFLS project is currently operating in. To that end, we reviewed documents dating from before the integrator contract award in December 1999 through March 2004. Based on our review, we determined that the operational structure and timeline originally developed and used as a basis for the acquisition strategy, pre-award review, and final contract award was altered in June 2002. The alteration moved the project terminology away from the use of the term *phases* to the use of the term *milestones*. The alteration also broke out the work to be performed under the original Phase IV into more detailed milestones and extended the anticipated completion date for the project to a considerably later date than originally planned. The effect of the alteration was negligible on the original Phases I, II, and III since they were completed by the date of the change.

To reiterate, in our opinion the reorganization of the operational work structure that occurred in June 2002, was simply a delineation of the original Phase IV work into the newly required milestone terminology. It is clear from the information we reviewed, and have presented below, that the CoreFLS project had moved past Phases II and III and into Phase IV prior to the June 2002, change in the organizational work structure. In fact, at the time of the organizational change, Phase IV work had been ongoing for close to a year.

The new milestone structure simply separated the original Phase IV work into more detailed and identifiable work units. This more detailed structure has resulted in a higher visibility of the work still to be performed and has allowed for better monitoring of the various tasks and work products required. However, the milestone structure does not change the fact that the CoreFLS project had entered Phase IV of the original work structure on or about May 25, 2001.

We developed a depiction of the original phase structure and the current milestone structure that highlights the relationship between the two structures and supports our conclusion that Phase IV services have been and continue to be rendered. The detailed information we reviewed in developing our conclusion is provided after the depiction shown on the next page.

**Original CoreFLS Project Organizational Work Structure
and Timeline Using Phases**



Details of Review

As originally developed, the CoreFLS project consisted of four major phases. Phase I was completed by BAH under a separate contract award. The work remaining under Phases II, III, and IV was outlined in the FY 2001 Capital Investment.

The proposal application submitted to the CIB on July 28, 1999 identified the following phases:

Phase II	Phase III	Phase IV
<p><i>Acquisition Planning</i> (May 1999 – Jan 2000). This includes the following activities: Form Steering Committee, Conduct BPR, Define Data, Design IT Infrastructure, and Develop IRM Authority Request.</p>	<p><i>Acquisition</i> (Sep 1999 – Sep 2000). This includes the following activities: Release Request for Information (RFI) and Request for Proposal (RFP), Evaluate Proposals, Select Vendor, and Prepare Implementation Plans.</p>	<p><i>Implementation</i> (Oct 2000 – Sep 2002). This includes the following activities: Design and Team Training, Test (including Data Conversion and System Interfaces), and Roll-out and User Training.</p>
<p>The major project milestones and specific metrics related to those milestones are depicted as follows:</p>	<p>The major project milestones and specific metrics related to those milestones are depicted as follows:</p>	<p>The major project milestones and specific metrics related to those milestones are depicted as follows:</p>
<p>Phase II – Acquisition Planning Time Frame</p>	<p>Phase III – Procurement Time Frame</p>	<p>Phase IV – Implementation Time Frame</p>
<p>VA BPR Workgroups May 1999-Dec 1999</p>	<p>BPR Phase II Jan 2000-Sept 2000</p>	<p>Category B Training Oct 2000-Jan 2001</p>
<p>IT Requirements May 1999-Dec 1999</p>	<p>Vendor Proposals Jan 2000-April 2000</p>	<p>BPR Phase III Oct 2000-Jan 2001</p>
<p>Interface/Database Design May 1999-April 2000</p>	<p>Technical Evaluation & Demos April 2000-July 2000</p>	<p>Functional Design: COTS Tailoring Interface Development Report Development Mini-System Dev. Data Conversion Dec 2000-Sept 2001</p>
<p>IRM Authority Nov 1999-Dec 1999</p>	<p>Cost Evaluation & BAFO July 2000-Aug 2000</p>	<p>System Simulations June 2001-Sept 2001</p>
<p>Legal/Technical Review Sep 1999-Jan 2000</p>	<p>Vendor Selection Sept 2000</p>	<p>Category C Training In Support of the Rollout Schedule Aug 2001-Aug 2002</p>
<p>Prepare and Issue RFI Sep 1999-Dec 1999</p>		<p>Rollout Pilot Implementation Sep 2001-Oct 2001 Full Implementation Nov 2001-Sep 2002</p>
<p>Prepare and Issue RFP Sep 1999-Jan 2000</p>		

The project was broken out into three phases, with milestones under the phases. Within this structure, the milestones were to represent groups of work units representing well-defined completion points that could be tracked and measured within the phases. The original implementation schedule for the project planned on completion (full implementation) of the project in September 2002.

As can be seen from the phase descriptions, the product which signaled the end of Phase II and the beginning of Phase III was the end of acquisition planning and the resulting issuance of the RFP for the CoreFLS software solution. The action that marked the end of Phase III and the beginning of Phase IV was the selection of the CoreFLS software solution vendor in Phase III.

This phase breakdown/structure remained substantially the same throughout the integrator services acquisition, award, and contract performance up until June 2002. Documents which evidence this are detailed below.

- The November 24, 1999, document entitled, “Integrated Financial and Logistics Management Standards (IFMS) Core Financial and Logistics System Integration Partner” states, “The first phase of the replacement effort has been completed, accomplishing the development of high level user requirements, conducting a market survey and proof of concept laboratory candidate commercial off the shelf federal financial systems, and preparing and obtaining approval of a capital investment proposal for the replacement CFLS solution. VA will complete the acquisition and implementation of CFLS in three board phases, described below.”

Phase II	Phase III	Phase IV
<p>VA requires expert assistance and participation in <i>acquisition planning</i>. Tasks will include participation in the preparation of requirements documents, evaluation and selection criteria, risk assessments and expert technical and business advice to the CFLS program managers.</p>	<p>CFLS Phase III will consist of the <i>actual acquisition</i> of the CFLS solution. Expert advice and technical assistance will be needed from the Integrator in the preparation and issuance of the acquisition documents, evaluation and selection, and implementation planning for nationwide application of the enterprise-wide CFLS solution.</p>	<p>CFLS Phase IV will consist of prototyping and implementation of the enterprise-wide CFLS application.</p>
<p>Period of Performance: January 1, 2000, to September 30, 2000</p>	<p>Period of Performance: October 1, 2000, to September 30, 2001</p>	<p>Period of Performance: October 1, 2001, to September 30, 2003⁵³</p>

- The December 10, 1999, acquisition methodology document states:

The project has been segregated into four phases. Phase I being the planning phase, this phase has already been completed. Phase II is the Business Process Reengineering. Phase III is the acquisition of the Commercial Off the Shelf core financial and logistics software package. Phase IV is the implementation of the software package.

- The December 10, 1999, SOW document sent with the Request for Quotation (RFQ) to the final four firms competing for the integration award, and the SOW attached to the December 22, 1999, award to the selected integrator, BearingPoint, states:

⁵³ September 30, 2003, is not consistent with other planning documents in and around the November 1999 time frame which show the end of Phase IV as September 30, 2002.

VA seeks the support of an Integration Partner who will provide subject matter expertise to assist the Core FLS project team in three areas:

- Provision of expert advice to the Core FLS project team and participation in business process reengineering, information technology assessment, and functional and technical requirements definition, and acquisition planning for a Core FLS solution (referred to as Core FLS Phase II).
- Expert advice for acquisition of a Core FLS solution (Core FLS Phase III).
- Expert advice for prototyping and implementing of a replacement integrated financial and logistics Core FLS solution (Core FLS Phase IV).

- Shortly after award of the contract, BearingPoint presented a deliverable to the VA dated January 19, 2000, entitled “Integrated Financial and Logistics Management Standards (IFMS)/Core Financial and Logistics System (CFLS) Accelerated Acquisition Strategy.” Within this document the project phases are outlined as follows:

Phase II	Phase III	Phase IV
Evaluate BPR with Most Efficient Organization (MEO) target, develop acquisition plans for new systems.	Release RFP, select COTS Package, Refine BPR based on COTS Selection.	Train, test, prototype, implement COTS system and extensions.
Period of Performance: January 2000 to September 30, 2000	Period of Performance: October 1, 2000 to September 30, 2001	Period of Performance: October 1, 2001 to September 30, 2002

This document in particular shows that the selected integrator, BearingPoint, had an understanding of the organizational work phases under which the CoreFLS project was to be performed and managed. BearingPoint understood the effort to be performed and the work products/deliverables to be produced under each phase and their delineation of the phases is consistent with the phases developed in the original acquisition methodology. There was no change in the content of the phases between the solicitation and the award to BearingPoint.

- Lastly, in the Capital Asset Plan (Exhibit 300) OMB A-11, the FY 2003 Budget Submission states:

Currently we have completed Phases I, II and III of the project, which comprised the planning and acquisition stages of the project, Phase IV, Enterprises Build and Implementation Phase is underway.

As is documented above, the CoreFLS project was originally set-up with well-defined phases ending with full implementation of the project.

The award made to the selected integrator, BearingPoint, on December 22, 1999, was for Phase II only. However, within the acquisition methodology it states, "...it is anticipated that if the contractor is successful on this task order that a task order for Phase III and then Phase IV will be issued to the same contractor." What is not clear in the acquisition methodology is how the CoreFLS program office would document the determination that the integrator had successfully completed the Phase II tasks, or how the switch from ordering Phase II services to ordering Phase III and ultimately Phase IV services would be clearly identified and executed. We based our conclusion that the project had moved into Phase IV work by comparing the actual work performed, and/or products deliverable under the issued task orders, to the work required under the phases. Our detailed review follows:

Phase II as originally described ended with the development of the acquisition plan for the CoreFLS software solution. In our opinion, Phase II ended on April 11, 2000. Our opinion is based on the following:

We found a document dated March 9, 2000, entitled, "Acquisition Strategy for Core/FLS" which detailed the strategy for acquiring the software for the CoreFLS project. Within that document it states that the VA will use the strategy of purchasing the software from the GSA Schedule 70 contracts. By using this strategy, the VA determined they would not have to develop a formal acquisition document (RFQ/RFI) and would not have to require formal submissions from the vendors. Shortly thereafter, on April 11, 2000, a White Paper for CoreFLS was issued in FedBizOpps explaining that the VA was gathering information on JFMIP certified software on the GSA FSS schedule 70 to select a software solution which will provide VA with the CoreFLS. The White Paper detailed the types of qualifications VA will consider and stated that VA would establish a BPA with the selected vendor and purchase the necessary software to conduct a conference room pilot. In our opinion, this White Paper was the end result of the acquisition planning process.

We also identified that BearingPoint submitted the following deliverables to VA which relate to the acquisition planning:

- CoreFLS Acquisition Planning Document, dated March 22, 2000.

- CoreFLS Assessment of Acquisition Planning Documentation, dated February 29, 2000.
- CoreFLS COTS Vendor Key Discriminators document, dated March 14, 2000.

The deliverables evidence that BearingPoint had provided the acquisition planning services required under Phase II and the issuance of the White Paper signaled the end of the planning phase and the start of Phase III which represented the selection process for acquiring the services of COTS software vendors.

Phase III as originally set-up ended with the selection and acquisition of the software solution. In our opinion, Phase III ended on May 25, 2001, with task order for supplies, number J14045, issued to Oracle Corporation for program licenses in the amount of \$19,504,495. Oracle was selected as the CoreFLS federal financial software solution provider, and this order appears to represent the initial purchase of Oracle program licenses.

Thus, in our opinion, based on the original phased work structure, all work performed by BearingPoint since May 25, 2001, would fall under Phase IV – Implementation.

As noted earlier, in June 2002, a change in the project organizational work structure occurred. The use of the phases appears to have been abandoned and in their place milestones were created. The first evidence we see of this change is in the FY 2004 “Part I. Capital Asset Plan and Business Case (All Assets)” submission. This document states:

The CoreFLS Project has undergone Milestone 0 – Project Initiation and Milestone 1 – Prototype Development and is currently beginning Milestone 2 – System Development phase of the project lifecycle.

The same document provides the following outline of the milestones developed for the project, along with their planned and actual period of performance (POP):

Milestone 0 - Planning Project Initiation	<u>Actual POP</u>	
- Phase I Planning & Project Development	06/99 – 03/00	100% Complete
- Acquisition Planning	03/00 – 04/01	100% Complete
- Acquisition	05/01 – 07/01	100% Complete
Milestone 1 – Prototype		
- Development	07/01 – 06/02	100% Complete
Milestone 2 – System Development	<u>Planned POP</u>	
- Enterprise Build Phase I (Focus Site)	07/02 – 10/02	
- Enterprise Build Phase II (Build 1.1)	11/02 – 06/03	

	<u>Planned POP</u>
- Enterprise Build Phase III (Build 1.2 & User Acceptance Testing)	07/03 – 04/04
Milestone 3 – System Deployment	
- Deployment Training Phase	05/04 – 09/05
- Phase 6 Deployment Rollout Phase	10/05 – 03/06
Milestone 4 – Post Implementation Reviews	
- Documentation & Maintenance	04/06 – 03/07
- Management & Evaluation	04/07 – 09/07

The most recent documents we reviewed include the FY 2005 OMB Exhibit 300 and the CoreFLS program office's March 31, 2004, milestone chart. These documents show that the milestone structure as detailed above is still the organizational structure being used to track the progress of the project. The only update to the structure, as of March 31, 2004, Milestone 2 - Enterprise Build Phase I (Focus Site) and Milestone 2 - Enterprise Build Phase II (Build 1.1) is 100 percent complete. According to the program office, the program currently is in the last phase of Milestone 2 - Enterprise Build Phase III.

The revision of the project's organizational work structure into milestones actually did not significantly alter the status of the project. Acquisition planning and actual acquisition (original Phase II and III activities) are grouped under Milestone 0 and recognized as 100 percent complete as of July 2001. This is only two months later than we believe the acquisition phase was completed and shows that, at the time of the June 2002 revision, there was an awareness that Phase II and Phase III of the original project timeline had been completed. The expansion of the original Phase IV work into several milestones, instead of just one milestone, does not negate the fact that all the activities listed under the new milestones 1, 2, and 3 were originally envisioned as Phase IV work.

BearingPoint Task Order Matrix

BearingPoint Task Order Matrix

Task Order (Mod) G07037 G07037 (1) G07037 (2) J01722 T1 J01722 (T1.1) J07122 CRP

Condition

Statement of Work (SOW) in file?	Y	Y	NA	Y	Y	N
Was the SOW written by the Government?	Y	N (1)	NA	N (1)	N (1)	NA
Did task order contain an IGCE?	N	N	NA	N	N	N
Was a technical evaluation completed?	N	N	NA	N	N	N
Did Bearing Point's work plan propose hours by task and skill mix?	N	N	NA	N	Y	N
Did the technical evaluation comment on the contractor's technical solutions and skill mix?	NA	NA	NA	NA	NA	NA
Were deliverables identified in each SOW/task order?	Y	Y	NA	Y	Y	Y

N(1) SOW is the same date as KPMG/BearingPoint's proposal.

BearingPoint Task Order Matrix

Task Order (Mod) **J07122 CRP (1) J07122 CRP (2) J17073 PM J17073 PM (2) J17073 PM (1) J17073 TI J17073 COTs**
9/27/2001

Condition

Statement of Work (SOW) in file?	N	Y	Y	N	NA	Y	N
Was the SOW written by the Government?	NA	N (2)	N (2)	NA	NA	N (2)	NA
Did task order contain an IGCE?	N	N	N	N	NA	N	N
Was a technical evaluation completed?	N	N	N	N	NA	N	N
Did Bearing Point's work plan propose hours by task and skill mix?	Y	N	N	N	NA	N	N
Did the technical evaluation comment on the contractor's technical solutions and skill mix?	NA	NA	NA	NA	NA	NA	NA
Were deliverables identified in each SOW/task order?	Y	Y	Y	Y	NA	Y	Y

N(2) Questioned authorship of SOWs. SOWs appear to be copies of contractor's proposals or SOWs are dated after contractor's proposals.

BearingPoint Task Order Matrix

<u>Task Order (Mod)</u>	J17073 COTs & TI (1) 7/1/2001	J17073 COTs & TI (1) 9/27/2001	J17073 DEP (1) 7/1/2001	J17073 DEP (1) 9/27/2001	J27009	J27012
Condition						
Statement of Work (SOW) in file?	N	NA	N	N	NA	NA Y
Was the SOW written by the Government?	NA	NA	NA	NA	NA	NA N (3)
Did task order contain an IGCE?	N	NA	N	N	NA	NA N
Was a technical evaluation completed?	N	NA	N	N	NA	NA Y
Did Bearing Point's work plan propose hours by task and skill mix?	N	NA	N	N	NA	NA N
Did the technical evaluation comment on the contractor's technical solutions and skill mix?	NA	NA	NA	NA	NA	NA N
Were deliverables identified in each SOW/task order?	Y	NA	Y	Y	NA	NA Y

N(3) SOW and work plan are almost identical except for a few word changes such as changing contractor to KPMG.

BearingPoint Task Order Matrix

Task Order (Mod) **J37184 J37238 J37229 J37230 J37237 J47117 J47098 J47118 J47061**

Condition

Statement of Work (SOW) in file?	N	N	N	N	Y	Y	Y	Y	N
Was the SOW written by the Government?	NA	NA	NA	NA	N (2)	N (5)	N (5)	N (5)	NA
Did task order contain an IGCE?	N	N	N	N	N	N	N	N	N
Was a technical evaluation completed?	Y	Y	Y	Y	Y	Y	Y	Y	Y
Did Bearing Point's work plan propose hours by task and skill mix?	Y	N	N	Y	N	N	Y	N	Y
Did the technical evaluation comment on the contractor's technical solutions and skill mix?	N	N	N	N	N	N	N	N	N
Were deliverables identified in each SOW/task order?	Y	Y	Y	Y	Y	Y	Y	Y	Y

N(2) Questioned authorship of SOWs. SOWs appear to be copies of contractor's proposals or SOWs are dated after contracto'r proposals.

N(5) SOW is part of Section C of award document SF 1449. Section C is the same as the contractor's submitted workplan.

OIG October 2, 2003 Memorandum

**Department of
Veterans Affairs**

Memorandum

Date: October 2, 2003

From: Assistant Inspector General for Auditing (52)

Sub: Evaluation of Transition Risks Associated with CoreFLS Build 1.2

To: Assistant Secretary for Management (004)
VA CoreFLS Project Director (042)

1. We are providing this memorandum to reiterate our concerns over the speed of the planned implementation of the Core Financial and Logistics System (CoreFLS). We expressed our concerns from our observations of testing at the Bay Pines Medical Center in a briefing to CoreFLS Project Director held on September 11, 2003.
2. The purpose of our evaluation was to identify potential risk areas in the implementation of CoreFLS, Build 1.2 on October 6, 2003. Our evaluation included a review of the Independent Verification and Validation (I,V&V) report, security report, training and Joint Financial Management Improvement Program (JFMIP) documents, observation of tests performed at Bay Pines Medical Center, and interviews of staff. We performed our limited scope evaluation work from August 13, 2003 to September 11, 2003. We focused our evaluation on risks associated with conversion techniques published by JFMIP.
3. The JFMIP published a white paper "Parallel Operation of Software: Is It a Desirable Software Transition Technique?" dated October 21, 2001. This document is intended to assist agencies in developing appropriate risk mitigation strategies when transitioning to new financial systems, especially Commercial-Off-The-Shelf (COTS) systems, without running parallel operations on the existing system. This document identified 6 activities that may be helpful in assessing transition risk associated with replacing a financial system.
4. We identified risks in 3 of the 6 areas. Our evaluation revealed unmitigated risks associated with: 1) continuity of operation, disaster recovery, and security plans; 2) training plan; and 3) quality assurance and compliance.

For example:

- Service contingency plan did not help ensure critical operations continue without interruption. The contingency plan was incomplete and had not been tested.
 - A comprehensive roll back contingency plan had not been completed. A contingency plan to bring the legacy applications back on-line had not been completed.
 - Training may not adequately prepare end-users. Some training modules were still in development and had not been posted to the training portal. Our review of the training modules disclosed an inadequate amount of training time. For example, the average training time provided for accounts payable was 7 hours. In addition, we observed several VA employees did not know how to perform accounting duties using CoreFLS. We do not believe mitigating the risk by having BearingPoint staff operate CoreFLS is an appropriate response.
 - Business scenarios and foundation testing may be unreliable. We observed BearingPoint staff directing testers, inputting test results, and determining test results.
 - Performance results have not been substantiated. Our observations disclosed that:
 - i) all performance issues were not logged or reported;
 - ii) system performance was sluggish but reported as satisfactory;
 - iii) tests were not conducted on a Wide Area Network;
 - iv) audit trails were not configured during the test.
5. We are again raising these concerns for your consideration prior to the implementation at the three test sites on October 6, 2003. If you have any questions or wish to discuss the contents of this memorandum, please call me on (202) 565-4625 or Marie Maguire, Director, Financial Audit Division at (202) 565-7013.

//s//

MICHAEL SLACHTA, JR.
Assistant Inspector General
for Auditing

OIG November 12, 2003 Memorandum

Department of Veterans Affairs

Memorandum

Date: November 12, 2003

From: Assistant Inspector General for Auditing (52)

Sub: Evaluation of Deployment Risks Associated with CoreFLS Build 1.2

To: Assistant Secretary for Management (004)
VA CoreFLS Project Director (042)

1. We are providing this memorandum to reiterate our concerns over unmitigated risks identified with the October 6, 2003, deployment of Core Financial and Logistics System (CoreFLS) and to help minimize the risk associated with future deployments. We expressed our concerns resulting from our review at the Bay Pines Medical Center in a briefing to the CoreFLS Project Director held on October 16, 2003.
2. The purpose of our evaluation was to identify potential risks associated with implementation of CoreFLS scheduled for February 2004. Our evaluation included a review of the Independent Verification and Validation (IV&V) report, selected system logs and configurations, major issues and gaps resolution plan, interviews of end-users and project staff, and observation of operations. We performed our limited scope evaluation work from October 14, 2003, to October 31, 2003. We focused our review on identifying risks in the deployment compared to standards and regulations.
3. Our evaluation revealed unmitigated risks associated with: 1) system security; 2) user roles and responsibilities; 3) user support; 4) system performance; 5) data conversion; and 6) system interfacing. For example:
 - Duties have not been segregated. We identified 8 BearingPoint users who have both application developer and system administrator rights. Another 15 BearingPoint users have system administrator rights in the production environment. Because audit trails have not been fully configured and do not provide sufficient information related to individual accountability, reconstruction of events, and intrusion detection, we were unable to determine the extent of their activity. As a result, programs and data are at risk of inadvertent or deliberate misuse, fraudulent use, and unauthorized alteration or destruction occurring without detection.

Additionally, controls over contingency planning need strengthening. On October 17, 2003, we observed a two-hour disruption in service. The disruption was due to a memory-related error. Procedures were not in place to facilitate recovery.

- Some user roles and responsibilities were incorrect. Four of 10 end-users interviewed were not assigned the appropriate roles and responsibilities. Two end-users were granted access rights to modules outside the scope of their responsibilities and 2 end-users did not have access to all the modules related to their responsibilities.
 - User support needs to be strengthened. Sufficient training was not provided to all end-users. Three of 10 end-users interviewed did not complete all required training. All 10 end-users expressed concern that the training was too general for their job needs. Furthermore, help desk support needs to be improved. Seven of 10 end-users stated the help desk did not resolve their issues in a timely manner. In fact, several issues were older than 4 days. Two of the 10 end-users stated the help desk was completely unresponsive.
 - All performance related issues were not reported. Three of 10 end-users interviewed stated they experienced slow response time on the day we conducted our interviews. The slow response times were not reported to the help desk. On several occasions it took approximately 5 minutes to log on to the system and on many occasions the system's response times were between 20 to 60 seconds.
 - Data conversion problems resulted in interruption of critical operations. Some medical supplies were not transferred from the warehouse to the distribution section due to incompatible units of measure between the legacy system and CoreFLS. Also, converted purchasing vendor files were missing contact numbers and account numbers.
 - Interfacing with other systems needs enhancement. In two separate instances, transactions were input into Veterans Health Information Systems and Technology Architecture (VistA) and Personnel Accounting Integrated Data (PAID) system and held in CoreFLS without updating the appropriate accounts.
4. We are again raising these concerns for your consideration prior to the upcoming deployment in February 2004, at the Tampa Medical Center, St. Petersburg Regional Office, Bay Pines Cemetery, St. Augustine Cemetery, and the Records Management Center. If you have any questions or wish to discuss the contents of this memorandum, please call me on (202) 565-4625 or Marie Maguire, Director, Financial Audit Division at (202) 565-7013.

//s//

MICHAEL SLACHTA, JR.
Assistant Inspector General
for Auditing

cc: Chief Financial Officer for Veterans Health Administration (17)
Chief Financial Officer for National Cemetery Administration (402A)
Chief Financial Officer for Veterans Benefits Administration (24)
Associate Deputy Assistant Secretary for Cyber and Information Security (045C)

OIG December 23, 2003 Memorandum

**Department of
Veterans Affairs**

Memorandum

Date: December 23, 2003

From: Deputy Assistant Inspector General for Auditing (52A)

Sub: Follow-up Evaluation of Deployment Risks Associated with CoreFLS Build 1.2

To: Assistant Secretary for Management (004)
VA CoreFLS Project Director (042)

1. At the request of the Assistant Secretary for Management, we conducted a follow-up evaluation at the Bay Pines Medical Center to determine if risks identified in the Office of Inspector General's memorandum "Evaluation of Deployment Risks Associated with CoreFLS Build 1.2" issued on November 12, 2003, have been mitigated. We are providing this memorandum to reiterate our concerns regarding unmitigated risks identified during our follow-up evaluation of the deployment of Core Financial and Logistics System (CoreFLS). We expressed our concerns in a briefing to the CoreFLS Project Director held on December 11, 2003.
2. The purpose of our evaluation was to identify potential risk areas in the implementation of CoreFLS and observe Build 1.3 business scenarios and foundation testing. Our evaluation included a review of selected system logs and configurations; interviews of end-users, hospital, and project staff; and observation of operations and testing. We performed our limited scope evaluation from December 2, 2003, to December 11, 2003.
3. Our follow-up evaluation revealed high levels of risk remain with: 1) system security; 2) user support; 3) data conversion; 4) system performance; and 5) system interfacing. For example:
 - System security weaknesses continue to put programs and data at risk of inadvertent or deliberate misuse, fraudulent use, and unauthorized alteration or destruction without detection. We identified incompatible duties for nine BearingPoint users who have both application developer and system administrator rights, an additional three BearingPoint users who have both security administrator and system administrator rights, and another 17 BearingPoint users who have system administrator rights in the production environment.

Additionally, audit trails have not been fully configured to provide sufficient information related to individual accountability, reconstruction of events, and intrusion detection. For instance, audit trails for inventory, fixed assets, and invoice payment tables have not been enabled and audit trail reports have not been fully developed.

Furthermore, controls over contingency planning need strengthening. Beginning November 19, 2003, non-emergency surgical procedures were suspended for 3 days due to the lack of key medical supplies and equipment necessary to perform surgeries. Procedures were not in place to facilitate obtaining needed supplies and equipment sooner.

- Also, access authority was not appropriately limited to authorized users. For instance, an employee with access to accounts payables in the Veterans Health Administration can view accounts payable data in Veterans Benefits Administration and National Cemetery Administration database files.
- The need to strengthen user support persists. All seven end-users interviewed stated electronic training was too general for their job needs. One employee stated training did not provide sufficient instruction on how to check the status of a purchase order and how to place an order from the warehouse to the supply, processing, and distribution center. Another employee stated training did not provide sufficient instruction on how to set up a vendor file, which is necessary to make a purchase. Considerable improvement in system navigation and transaction processing by Supply, Processing, and Distribution staff and Material Management Services staff occurred after attending a hands-on training workshop.

Additionally, help desk support continues to need improvement. Three out of seven end-users interviewed stated the help desk did not resolve their issues in a timely manner. One end-user showed us an outstanding help desk ticket dated October 24, 2003, that was still pending as of the first week of December 2003. As of December 10, 2003, the project team's help desk metric report disclosed a 21-day average open ticket period.

- Data conversion problems continue to impact critical operations. Medical supplies and equipment were not properly transferred from the warehouse to hospital wards due to incompatible units of measure between the legacy system and CoreFLS. Medical supplies were not ordered because purchasing vendor files were missing contact numbers and account numbers. Zero quantity inventories were not replenished due to inaccurate reorder quotients maintained in the legacy system. Accounts payables were not always paid on

time because some accounts did not have the correct information in the cycle field.

- System performance remains unsubstantiated. Significant improvement has been achieved measuring response times and isolating performance problems for Oracle super-users. The primary method for reporting performance related problems continues to be through the help desk, but all performance related issues were not reported. Even though notifications were posted throughout various work areas instructing end-users to report performance related issues to the help desk, three out of seven end-users interviewed stated they did not report all slow response times.
 - Interfacing with other systems needs further development. In several instances, transactions input into Veterans Health Information System and Technology Architecture (VistA) did not update the appropriate CoreFLS account. The end-user received a pre-validation error message after the nightly batch processing.
 - Build 1.3 business scenarios and foundation test results may be unreliable. We found that BearingPoint staff was directing testers, inputting test results, and determining test results, rather than VA employees. We observed a VA tester who was not familiar with the business process being tested. Accordingly, the system is not being appropriately tested by knowledgeable VA users.
4. We are providing this information for your consideration and appropriate action prior to deployment in February 2004 at the Tampa Medical Center, St. Petersburg Regional Office, Bay Pines Cemetery, St. Augustine Cemetery, and the Records Management Center. If you have any questions or wish to discuss the contents of this memorandum, please call me on (202) 565-8487 or Marie Maguire, Director, Financial Audit Division at (202) 565-7013.

//s//

JOHN BILOBRAN
Deputy Assistant Inspector
General for Auditing

cc: Chief Financial Officer for Veterans Health Administration (17)
Chief Financial Officer for National Cemetery Administration (402A)
Chief Financial Officer for Veterans Benefits Administration (24)
Associate Deputy Assistant Secretary for Cyber Security (045C)
Director, Bay Pines VA Medical Center (516/00)

Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 4, 2004

From: Acting Under Secretary for Health (10/10B5)

Subject: **Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)**

To: Assistant Inspector General for Auditing (52)

1. The referenced report has been carefully reviewed by program officials at all VHA organizational levels, and I accept your findings. I also concur in your recommendations. VISN 8 and the Bay Pines VAMC have consolidated detailed comments to the report, including comprehensive plans of corrective action for each recommendation, and these documents are included as attachments to our response. These issues have also prompted national policy review in every relevant area.

2. VHA is committed to assuring that problems at our Bay Pines facility are eliminated and that they will not recur. As you are aware, even prior to issuance of your interim report in March 2004, VISN and medical center officials had initiated interventions to correct existing conditions. Subsequently, the senior leadership at Bay Pines has experienced an almost complete turnover. A new Chief of Staff formally assumed responsibilities on July 11, 2004, and recruitment efforts are underway to fill key clinical positions. As described in the attached action plan, significant efforts are also being made to address organizational issues impacting staff morale, and to bolster a culture of safety that will permeate the entire facility. Medical center administrative functions are also being fully re-assessed. Individual clinical site reviews have been conducted to evaluate the effectiveness of the pulmonary and critical care, radiology, surgery and infectious disease programs, and action plans to address findings from these reports have been developed. These ongoing actions, and numerous others, are also addressed in the attached VISN/medical center comments.

3. For many months, senior VHA leadership has been personally and actively involved in overseeing improvement actions at Bay Pines. When issues at the facility first surfaced, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) was in personal daily contact with VISN and medical center officials to coordinate appropriate corrective actions. The DUSHOM continues to conduct

regularly scheduled weekly conference calls with VISN managers to discuss progress, and convenes other sessions whenever indicated. Liaison staff from that office also maintain open and close communication on a daily basis with the Florida offices. As part of VHA's monitoring efforts, VISN 8 maintains an ongoing, current daily tracking log of all related Bay Pines initiatives and emergent events and this log is shared with the VACO VISN liaison, who, in turn, keeps senior staff at the VACO level fully apprised of ongoing developments. The Office of the DUSHOM also routinely receives reports of all special investigations and reviews that are conducted at Bay Pines and coordinates plans of corrective action with VISN and facility managers, as well as with other clinical and administrative offices in VACO. Designated VACO staff will continue to monitor all actions through problem resolution, and will work cooperatively with your office in expediting closure of the recommendations.

4. You recommend that VHA develop and implement productivity standards for physicians, as directed by Public Law 107-135. A draft directive on staffing guidelines for VHA health care providers is now in the concurrence process and should be finalized for publication by the end of August 2004. In addition, VHA Directive 2004-031, "Guidance on Primary Care Panel Size," was published and distributed on July 6, 2004. This policy requires that all primary care practices establish maximum panel sizes for all primary care providers. We continue to work on a productivity model for specialty care providers, and are evaluating a model that directly measures clinical work using standard Relative Value Units as the numerator and physician FTEE as the denominator. This methodology offers the possibility for VHA to benchmark to the private sector, as well as to establish internal benchmarks for systematic performance monitoring. VHA is also exploring the feasibility of using a population-based model, the *Automated Staffing Assessment Model (ASAM III)*, developed by the United States Army Medical Command. We will need to do significant software engineering to automate the data necessary to bring the specialty care physician productivity project to fruition.

5. In summary, I reiterate VHA's firm commitment to resolving problems at the Bay Pines VAMC. I also strongly concur with your observation that the vast majority of our VA employees at that facility are dedicated, professionally competent and hard working individuals who extend themselves daily to meet the needs of our veterans. We are working diligently to re-establish a stable senior management force at Bay Pines and to regain veteran trust in knowing that high quality care is provided to them. I believe that the activities outlined in the attached action plan reflect that commitment. As the VISN action plan also notes, appropriate administrative actions have been initiated against the former Chief of Medicine. The DUSHOM has also initiated action against the former Chief of Staff, who has been reassigned as a staff cardiologist at another VA medical facility, effective June 2, 2004. We are reviewing information presented in your report to determine if additional sanctions are warranted.

6. Thank you for the opportunity to review the draft report. Please contact me if you have any questions about this response.

//s//

Jonathan B. Perlin, MD, PhD, MSHA, FACP

Attachments

VETERANS HEALTH ADMINISTRATION
Action Plan
OIG Draft Report: **Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)**

Recommended Improvement Action(s) 1. The Deputy Under Secretary for Operations and Management needs to ensure that the VISN formulates, reviews, and implements action plans to improve the leadership of the BPVAMC and ensure a “Culture of Safety” at the BPVAMC.

Concur

GOAL: To effectively monitor and assess VISN and facility performance in implementing action plans to improve operations at BPVAMC.

STRATEGY: VHA senior leadership has been actively involved in overseeing improvement actions and will continue to do so. Immediately following identification of the issues at the facility, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) maintained personal daily contact with VISN and medical center managers, and now has regularly scheduled weekly conference calls with VISN managers to discuss progress in outstanding issues. Liaison staff from the Office of the DUSHOM also are in daily contact with the Florida offices. As part of VHA’s monitoring efforts, VISN 8 maintains an ongoing, current daily tracking log of all related facility initiatives and emergent events, which is routinely provided to VACO liaison staff, who apprise senior managers of current activities. The DUSHOM also receives all internal and external investigative reports dealing with issues at Bay Pines, as well as media reports, and coordinates plans of corrective action with VISN and facility managers. Designated VACO staff will continue to monitor all actions through problem resolution, and work closely with the OIG to resolve report recommendations.

Recommended Improvement Action(s) 2: The Acting Under Secretary for Health in conjunction with the Deputy Under Secretary for Health for Operations and Management needs to develop and implement productivity standards for physicians as directed by Public Law 107-135.

Concur

GOAL: To develop and implement productivity standards for physicians as directed by Public Law 107-135.

STRATEGY: A draft directive on staffing guidelines for VHA health care providers will be published by the end of August 2004. Another VHA Directive 2004-031, "Guidance for Primary Care Panel Size," was published and distributed on July 6, 2004. VHA will continue to work on a productivity model for 2. VHA Action Plan

specialty care providers, and will evaluate available models. Currently, VHA is evaluating a model that directly measures clinical work using standard Relative Value Units as the numerator and physician FTEE as the denominator. VHA is also exploring the feasibility of using a population-based model that was developed by the U.S. Army Medical Command. Significant software engineering will have to be completed to automate necessary data for the specialty care physician productivity project.

Recommended Improvement Action(s) 4: The Deputy Under Secretary for Operations and Management needs to take appropriate administrative action against the former COS for not adequately supervising the former Chief, Medicine Service's spending of Pfizer, Inc. grant funds.

Concur

GOAL: To take appropriate administrative action against the former Chief of Staff.

STRATEGY: The Deputy Under Secretary for Health for Operations and Management has initiated administrative actions against the former Chief of Staff. This individual was reassigned as a staff cardiologist at another VA medical center, effective June 2, 2004. VHA will review information presented in OIG's report to determine if additional sanctions are warranted.

Office of Inspector General

Issues at VA Medical Center Bay Pines, Florida and Deployment of the Core Financial and Logistics System

VISN 8 and Bay Pines VA Medical Center Comments

August 4, 2004

This paper is the VISN 8 and Bay Pines VA Medical Center Directors' response to the "*Draft Report of the Office of Inspector General: Issues at VA Medical Center Bay Pines, Florida and Deployment of the Core Financial and Logistics System (CoreFLS)*." The following comments are offered by issue and recommendation. The VISN 8 Director and the BPVAMC Director express gratitude for the OIG's written acknowledgement about the "many hard working, professionally competent individuals who were "going the extra mile" to ensure that veterans receive quality health care. The vast majority of the employees who work at the Bay Pines VA Medical Center truly exhibit these characteristics.

Issue 1: Clinical Management and Administration

Recommended Improvement Action(s) 1. The Deputy Under Secretary for Operations and Management needs to ensure that the VISN formulates, reviews, and implements action plans to improve the leadership of the BPVAMC and ensure a "Culture of Safety" at the BPVAMC.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

The senior leadership at the BPVAMC has essentially experienced a total turnover. Mr. Smith Jenkins assumed his duties as VAMC Director in August 2003. The Chief of Staff was reassigned to the role of staff physician at the Richmond VAMC. A new Chief of Staff has been selected and formally assumed duties on July 11, 2004. An Acting Chief, Medicine Service was detailed from the role of Chief Medical Officer at the Orlando OPC. In April 2004, the Associate Director was detailed to work in Afghanistan as part of a national VA project. The effective date of this detail was May 9, 2004. As of July 19, 2004 she has been detailed to VISN 8. An Acting Associate Director who is a member of the VISN 8 staff was

identified and assumed those duties immediately. Recruitment efforts are underway for the following positions:

- ❑ Chief, Radiology Service
- ❑ Chief, Medicine Service
- ❑ Chief, Pathology and Laboratory Medicine Service
- ❑ Chief, Surgery Service
- ❑ Chief, Anesthesiology Service

BPVAMC senior leadership is continually addressing communication with the clinical staff. The Medical Staff Executive Committee (MSEC) includes membership from each of the clinical specialties—medicine, surgery, geriatrics and extended care, psychiatry (mental health), laboratory, radiology, and nursing. Meetings of the Medical Staff Executive Committee are documented and now include a roster of members in attendance and members absent. The Acting Chief of Staff evaluated the agenda for the Medical Staff Executive Committee and has taken steps to ensure that the primary area of focus for the meetings is the clinical care of patients. He has also made sure that all members receive copies of the minutes of these meetings. One of primary roles of the Chief of Staff is to continually evaluate the productivity of the clinical staff and ensure that patient care requirements are met.

In early 2004, the Deputy Under Secretary for Health for Operations and Management directed the National Center for Organizational Development (NCOD) to begin working with BPVAMC to address organizational issues impacting staff morale. The formal process for this consultation began in April 2004. An all-employee survey was conducted as the first step in their evaluation process. The results of this survey are being used to design the organizational development interventions needed to improve the “Culture of Safety.”

The following steps have been taken or are in process to ensure a culture of safety:

1. A VISN-wide *Culture of Safety* employee survey was conducted in March 2004 as a means of determining current employee perceptions, knowledge, attitudes and beliefs about the organizational culture of safety. The preliminary results for BPVAMC were relatively consistent with the rest of VISN 8. An in-depth analysis of the results of the survey is underway. After the analysis is complete, a detailed action plan addressing each of the survey recommendations will be developed.
2. Plans are being made for a Bay Pines Patient Safety Conference. Staff from the VHA National Center for Patient Safety, including Dr. Jim Bagian, the National Director, is being invited as guest speakers. Staff working with the VHA/NASA Patient Safety Reporting System will also be invited to speak.
3. In June 2004, Bay Pines held its annual Quality and Safety Fair during which all of the Joint Commission's National Patient Safety Goals were presented for staff education purposes.
4. Staff from the VISN 8 Patient Safety Center of Inquiry has been invited to the BPVAMC to discuss safety research initiatives for potential local implementation.
5. The VISN 8 Patient Safety Officer will continue to collaborate with BPVAMC patient safety staff to determine and implement ongoing patient safety initiatives.

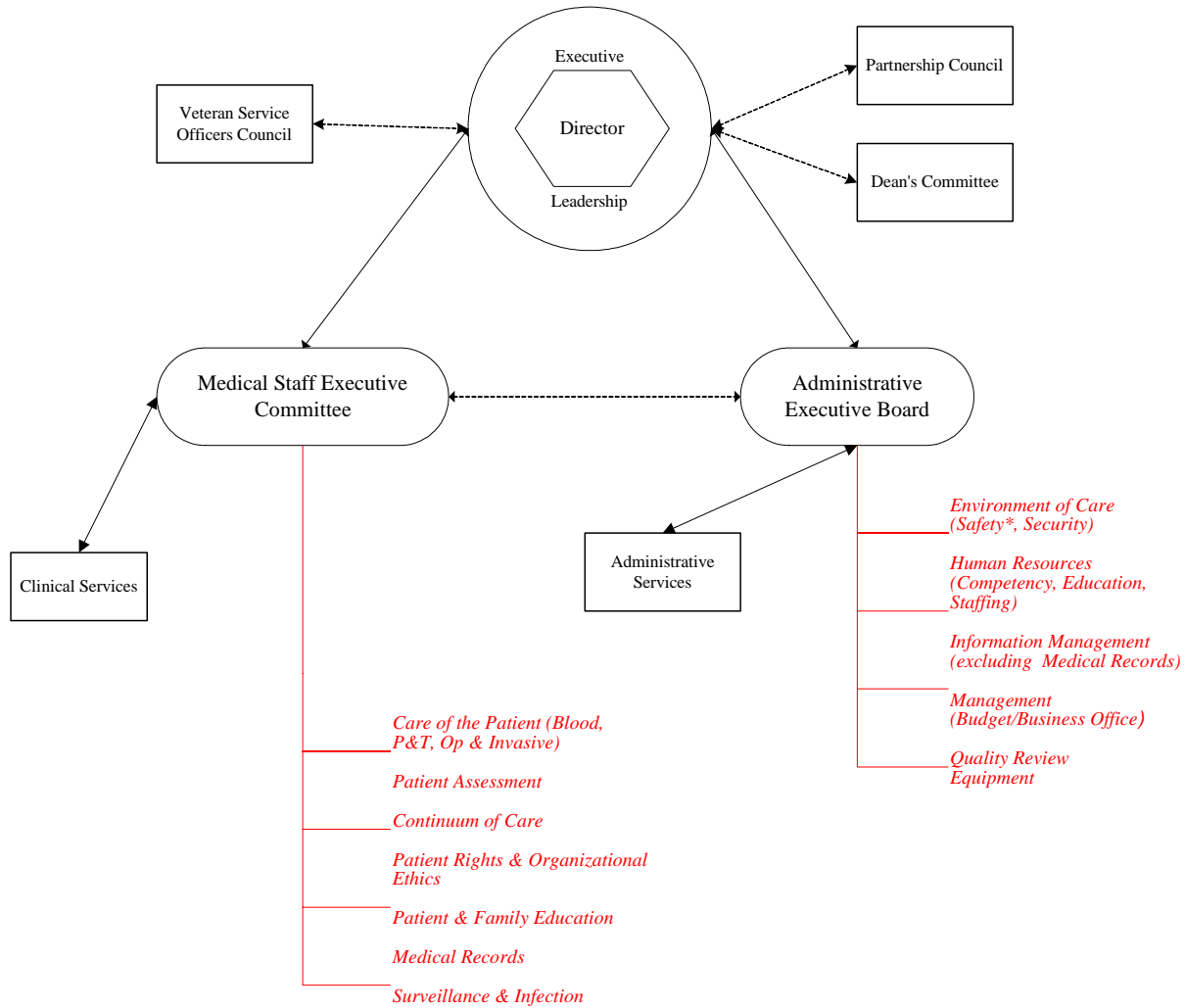
In order to determine the effectiveness of the above actions, a follow-up *Culture of Safety* employee survey will be conducted in March 2005.

Recommended Improvement Action(s) 3. The Director VISN 8, in conjunction with the Medical Center Director, needs to:

- a. Ensure that BPVAMC resumes a formal AEB or similar administrative committee structure, that documents senior management discussions, decisions, action plans, and solutions.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

The BPVAMC administrative services have been evaluated. As part of this evaluation, the flow of information and communication was reviewed to ensure that all administrative functions are addressed. As an interim step, the role and functions of the current "Resources Board" have been expanded to include the common reporting requirements for administrative services. The membership has been expanded to ensure clinical representation and input into administrative and budgeting processes. The minutes of the revised "Resources Board" now include discussion, decision, action plans, and solutions. A formal Administrative Executive Board is under development to address the requirements of VHA. It is anticipated that the AEB will be fully functional by October 2004. The functional communication flow of information is reflected in the diagram that follows:



Recommended Improvement Action(s) 3. The Director VISN 8, in conjunction with the Medical Center Director, needs to:

- b. Request that The Bay Pines Foundation, Inc. bill the former Chief of Medicine \$8,905 to recoup funds donated for a “mini-medical school” program, which he improperly spent.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

VHA has requested specific documentation that identifies the person who directed the disbursements and the certifying officer. Upon receipt, the Director, BPVAMC will review the expenditures and initiate a bill of collection to the former Chief of Medicine.

Recommended Improvement Action(s) 3. The Director VISN 8, in conjunction with the Medical Center Director, needs to:

- c. Take appropriate administrative action against the two employees who approved the use of grant funds from Pfizer, Inc. for not ensuring the Bay Pines Foundations, Inc. furthered the interests of the Department and its research and education programs, and for not complying with the terms of the grant letter.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

VHA has requested specific documentation that identifies the person who directed the disbursements and the certifying officer. Upon review of individual accountability, the BPVAMC will initiate appropriate administrative action.

Recommended Improvement Action(s) 3. The Director VISN 8, in conjunction with the Medical Center Director, needs to:

- d. Require Ft. Myers SOC schedulers to enter initial audiology appointments requests as “next available” appointments and return visits as “other than next available appointments.”

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

VISN 8 has developed "VISN 8 Appointment Scheduling Guidance" to ensure consistency and accuracy of the scheduling process in all clinics. Clinic appointments will be scheduled according to VHA definitions and criteria. A mandatory PowerPoint slideshow will be presented to every employee with access to the scheduling package. Medical center directors are required to certify that the training has been provided. To ensure continued compliance, monitors have been identified that will be reported to the Executive Leadership Board on a regular basis. In addition VISN 8 will provide this information to the Deputy Under Secretary for Health for Operations and Management for continued oversight.

Bay Pines management developed and submitted an action plan to address backlog issues in audiology and ophthalmology, which clearly outlines their understanding of VA priorities. The memo establishes the BPVAMC action plan to provide audiology and ophthalmology services following established VHA policy. In addition, BPVAMC received VISN Guidance related to maintaining accurate waiting list information.

Oxygen Systems

Recommended Improvement Action(s) 3. The Director VISN 8, in conjunction with the Medical Center Director, needs to:

- e. Promptly resolve the bulk oxygen system deficiencies and brings the system into compliance with NFPA-99, NFPA-50 requirements, and the VHA PSA.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

To clarify the incident described in the OIG Report, no loss of oxygen to patient care areas occurred. The systematic process in place for responding to alarms successfully notified staff and prevented any adverse impact on patient care.

On April 2, 2004, the VISN 8 Safety Officer conducted a “Medical Gas Systems Review of the Bay Pines VAMC Oxygen Utility Incident of 1-17-04.” On April 30, 2004, a VISN 8 Liquid Oxygen Medical Gas Systems Task Force was established to review the process for standardizing liquid oxygen systems for VISN 8. The group was composed of utility, clinical, security, and administrative representatives from each medical center within VISN 8. The main focus of the group was to ensure that all VISN 8 Liquid Oxygen Systems comply with **NFPA 99 at a minimum**. The VISN 8 Executive Leadership Board approved all of the recommendations. The VISN 8 Safety Officer has visited the BPVAMC to ensure compliance with the Patient Safety Alert Mandates and conducts periodic repeat visits to provide on-site follow-up.

Compliance with Patient Safety Alert Mandates sent from the DUSH OM in April 2004

1. *Conduct alarm-set point verification through the use of a qualified third party expert. The set points must be code compliant and this action documented. (Refer NFPA-99 5.1.3.4.11.6, 2002 Edition)*

BPVAMC completed the requirements of this mandate. The third party test was completed 6-14-04.

2. *Ensure that a minimum of two, independent 24/7 and constantly attended monitoring stations are provided for all alarm conditions related to the Oxygen Utility System. Test all alarm conditions to ensure the alarm annunciation is working. (Level 1 only).*

BPVAMC completed the requirements of this mandate. New NFPA compliant panels are located in the energy center and telephone operator room. Both are 24/7 sites of operation. This was completed 6-14-04 upon verification by the third party vendor. Alarms are tested monthly. The Chief, Engineering Service, maintains documentation records.

3. *If either of the conditions in 1 or 2 above cannot be met, the Medical Center must publish, over the Director’s signature, a comprehensive Interim Life Safety Measure that fully addresses and compensates for the non-compliant condition. The ILSM must remain in effect until the code requirements are met. In addition appropriate staff must be trained on the ILSM requirements, and this training needs to be documented.*

ILSM's are no longer required for BPVAMC due to completion of 1&2. However staff will continue the practice of daily inspection and reading of the bulk tank. Data are being used to track usage and are reported to the Medical Center Environment of Care Committee. Minutes of these meetings reflect data review and oxygen usage.

4. *Review the oxygen delivery contract and verify the delivery schedule meets current demands to ensure an adequate supply of Oxygen so alarm conditions are not triggered between refills.*

This has been the practice at BPVAMC and will continue. Daily manual oxygen supply readings are used as ongoing monitors for oxygen consumption.

5. *Ensure qualified and trained technical staff such as a Biomedical Engineering Technician, SPD Technician or Pipe Fitter monitors tank -refilling procedures.*

This mandate is partially completed with vendor provided training rendered to VA staff on 5/18/04. The vendor has been put on notice to fill only at times that will allow VA supervision. Notification by the contracting officer has been accomplished but the vendor has not achieved full compliance.

6. *Ensure an adequate supply of portable oxygen with an appropriate mixture of tanks is available for deployment at point of health care delivery in the event of total Oxygen Utility System failure. All tanks must be properly stored.*

An internal system review indicates that the availability of H cylinders needs to be doubled. BPVAMC is in process of implementing this mandate. Additional cylinders have been in place as of July 17, 2004

7. *Set, maintain, and document appropriate Oxygen Utility System preventive maintenance and testing protocols.*

This mandate has been completed with systematic processes in place for ongoing monitoring.

8. *Review Medical Center Utility Shutdown Policy, as required by JCAHO to assure appropriate safeguards are in place in the event of unplanned utility shutdowns.*

This mandate has been completed and safeguards are in place for unplanned utility shutdowns. Monitoring mechanisms are reviewed annually.

Recommended Improvement Action(s) 3. The Director VISN 8, in conjunction with the Medical Center Director, needs to:

- f. Establish a MOU with the local oxygen vendor that includes all the requirements of the NAC contract.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

Bay Pines VAMC uses the NAC contract for oxygen supply and services.

Recommended Improvement Action(s) 3. The Director VISN 8, in conjunction with the Medical Center Director, needs to:

- g. Establish procedures to monitor oxygen level readings and conduct routine site inspections.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

A systematic process for monitoring oxygen levels is in place. The process includes daily monitoring of oxygen levels by SPD staff. The Chief of SPD maintains documentation of these readings. Staff in SPD has received the proper training to monitor oxygen level readings and conduct routine site inspections. Training documentation is maintained in the employee competency folders.

Recommended Improvement Action(s) 3. The Director VISN 8, in conjunction with the Medical Center Director, needs to:

- h. Provide and document training to employees responsible for maintenance of the facility bulk oxygen system.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

As part of the compliance with the requirements of ILSM, an internal review of procedures for staff responsible for monitoring of and responding to conditions of low oxygen supply was conducted on April 29, 2004. This included the SPD supervisor, engineering operations supervisor, engineering equipment supervisor, respiratory therapy supervisor, biomedical engineer, and the Chief, Engineering Service. The oxygen vendor provided staff training on May 18, 2004. The topics included in this training were as follows:

- Reading of gauges
- Calculation of usage
- Understanding alarms
- How tanks are filled
- How tanks are emptied
- Required monitors
- Problems to look for
- What to do about ice build-up
- Contamination issues
- COTR qualifications

The Chief of SPD maintains the competency for SPD personnel for inspecting and supervising of oxygen tank refills. As part of this responsibility, the Chief of SPD also maintains continuous logs of the bulk oxygen system.

Recommended Improvement Action(s) 3. The Director VISN 8, in conjunction with the Medical Center Director, needs to:

- i. Obtain annual inspections of medical gas systems conducted by a qualified representative of the equipment owner.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

The oxygen vendor has been directed to provide emergency contingency plans and monitoring plans. Effective date: July 23, 2004

Recommended Improvement Action(s) 3. The Director VISN 8, in conjunction with the Medical Center Director, needs to:

- j. Install a larger capacity reserve tank.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

A 900-gallon oxygen reserve tank is planned as a replacement for the existing reserve tank. The date for this replacement is being negotiated with the vendor. The Chief, Engineering Service and the Contracting Officer are expediting this action. Completed and installed August 4, 2004

Issue 2: Care in Selected Clinical Services

Elective Surgery Backlogs Existed in Several Surgical Specialties

Recommended Improvement Action(s) 5. The VISN Director needs to ensure that the BPVAMC Director completes a comprehensive review of the Surgery Service, including surgical subspecialties, to ensure timely delivery of surgical care. Actions should be taken to notify our office when surgical timeliness deficiencies have been corrected, staffing adjustments have been made, and full OR capacity has been restored.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

During the week of April 20, 2004, a comprehensive site visit evaluating the Surgical Service was done by the National Director of Surgery, National Director of Anesthesia, Program Specialist OR Management, Operative Care Line Executive, Nurse Executive VACO and Associate Dean USF School of Medicine. Action plans to address the specific recommendations from their report have been developed. An internal process has been developed at BPVAMC to notify the OIG regarding surgical timeliness corrections, surgical staffing adjustments, and restoration of full OR capacity. The Department of Surgery maintains an active monitor of surgical case timeliness. The following table illustrates the current waiting times for the surgical subspecialties.

Pending Surgeries Report

	7-May-04	21-May-04	28-May-04	4-Jun-04	11-Jun-04	23-Jun-04	5-Jul-04	Currently Scheduling Into	Avg Days Wait	Surgeries sent out on fee since 2/12/04	Surgeries sent out on fee in last 60 days
Specialty											
General Surgery	45	45	43	50	48	46	44	late July	35	0	0
Orthopedics	142	134	127	127	126	126	150	mid Oct	110	54	4
Plastic Surgery	38	44	39	33	33	34	22	late July	25	0	0
Urology	87	87	80	80	79	79	80	late Aug	58	0	0
Ophthalmology	46	48	36	44	40	36	33	mid Aug	35	0	0
Thoracic Surgery	1	2	2	2	3	3	3	early July	4	0	0
Otolaryngology	10	8	6	9	8	4	7	early July	4	0	0
Vascular Surgery	16	10	9	9	9	14	13	late July	20	0	0
Surgical Podiatry	27	32	39	36	32	30	31	late Aug	56	0	0
Gynecology	0	3	0	0	4	1	0	early July	0	0	0
Total Pending	412	413	381	390	382	373	383				

A multidisciplinary OR committee has been formed to include representatives from surgery, anesthesia, and nursing. The first meeting of the committee was held on July 23, 2004. The committee has been charged with making improvements in the flow and function of the OR. The sixth room of the OR is a functional room became operational on July 7, 2004. This limitation was in part due to vacancies in nursing and anesthesia staff. New OR nurses were hired and are presently being trained. An additional CRNA is being recruited. New physicians have been hired for thoracic surgery, ENT, and neurosurgery (limited fee basis for clinics). The MOU for cardiac and neurosurgery was sent to local hospitals on July 1, 2004. Responses from community physicians and hospitals are pending. A meeting with a local cardiology group was held on July 12, 2004 regarding the proposed contract.

Orthopedic Surgery Backlog Reduction Action Plan. An action plan has been developed for reducing orthopedic surgery backlog. The background, current situation, and action plan are outlined below.

Background. The Orthopedic Surgery Section had 1 MD and 1 support staff member vacancies for an extended length of time. After these staff vacancies were filled, significant reductions were made in the backlog of consults in the orthopedic clinic. This reduced the waiting time for orthopedic clinic new consultations. However, there was a resulting increase in the number of orthopedic surgeries that needed to be performed. These events coincided with the implementation of CoreFLS and the need to reduce the surgery schedule by rescheduling surgical procedures due to problems in SPD. In addition, there was turnover of nursing and anesthesia personnel in the operating room with lags in recruitment, which resulted in the inability to consistently run 6 rooms at all times.

Current Situation. The Orthopedic Surgery Section currently has 145 surgical cases pending. These cases are scheduled through October 2004, based on medical need. The orthopedic section receives approximately 216 consults per month. Historically, 27% of orthopedic consults have resulted in surgical cases that need to be performed. This equates to 58 new surgical cases being identified each month. In FY 03, BPVAMC performed 37 orthopedic surgeries per month. In FY 04, 40 orthopedic surgeries per month were performed. Beginning in July 2004, 57 – 60 orthopedic cases per month will be performed. This will keep up with the incoming cases, but will not decrease the backlog. During FY04YTD, 54 patients were sent to the community for fee basis orthopedic surgery.

PLAN

1. Beginning in July 2004, orthopedics will operate one additional day per week, allowing them to operate five days a week. This will increase capacity to between 57 and 60 orthopedic surgeries per month.
2. Coordination is underway to give Orthopedics a second (additional) operating room beginning in September 2004. Orthopedics will run two rooms simultaneously once a week. Careful planning is required to assure equipment and instrumentation availability, inpatient bed availability, radiology support, and other support services needed to support post-operative care. These actions will increase capacity to 63 – 66 orthopedic surgeries per month. Additional equipment/instrumentation needs will be identified and procured.
3. When OR days become available with sufficient notice, Orthopedics will be offered the additional OR time.
4. An additional arthroscopy instrumentation set is being procured so that four arthroscopies can be performed per day.
5. An additional shoulder set is being procured so that three shoulder cases can be performed per day.
6. Orthopedic surgical cases will be sent to local medical facilities on fee basis as clinically indicated.
7. Plans to relocate and redesign the orthopedic clinic are in process. Improving patient flow and efficiency in the orthopedic clinic will improve staff utilization. This should positively impact the orthopedic support staff availability to assist in the operating room allowing additional cases to be completed.
8. The Acting Chief, Surgical Service will explore the advantages of bringing in an orthopedic surgeon through the VA National Contract for Professional Services to assist in clinic consultation to free up an orthopedic surgeon for OR cases.
9. An orthopedic surgeon will be assigned to go through the 150 orthopedic surgery cases pending greater than 30 days. On a case-by-case basis a determination will be made on the appropriateness of sending a patient for fee basis care so that the surgery can be performed sooner.

Radiology Service did Not Provide Timely and Adequate Support

Recommended Improvement Action(s) 6. The VISN Director, in conjunction with the Medical Center Director needs to:

- a. Ensure that radiographic examinations are scheduled and images are interpreted within required time frames.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

A comprehensive site visit by the VACO Director of Radiology Program was conducted on March 5, 2004. The purpose of the visit was to assess radiologist workload and productivity and to provide advice on reducing the backlog of unread studies.

Every week, each VISN 8 facility reports to the Executive Leadership Board on the following areas: number of studies waiting to be transcribed and verified, and the number of patients waiting greater than 30 days for CT scans, ultrasounds, MRIs, PET scans, general radiology, and thallium stress tests. Actions plans to ensure timeliness of radiology studies are continually updated. The pulmonary and radiology clinical staff will develop a fast tracking process for diagnosis and management of suspicious lung lesions. Timeliness and ongoing monitoring will be reported to the Medical Staff Executive Committee, requirements for which will be determined as part of the process being developed.

BPVAMC currently has vacant radiologist positions that are being aggressively recruited. The number of unread exams is monitored on a daily basis to ensure that exams are being read in a timely manner.

BPVAMC has taken numerous actions to ensure that radiographic images are interpreted within required timeframes. Actions taken include the following:

- Hired an additional full-time radiologist, increasing the number to five full-time radiologists
- Hired an additional fee-basis doctor, increasing the total number to four part-time fee-basis doctors
- Hired three locum tenens physicians to read radiology exams (the last locum tenens left on July 2, 2004)
- Established a contract with Renaissance Imaging Services to read images via tele-radiology
- Sending out 15 CT and MRIs per day locally to a local imaging center
- Sending patients in Fort Myers that require a specialty exam (CT, MRI, Mammography and Ultrasound) to a local imaging center

Recommended Improvement Action(s) 6. The VISN Director, in conjunction with the Medical Center Director needs to:

- b. Ensure that providers properly designate the urgency of radiological study requests.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

On page 30 of the OIG draft report, it states “Physicians often inappropriately classified radiology requests as ‘stat’ or ‘urgent’ because they believed that was the only way to obtain timely service for their patients.” Improved access to services has minimized the need for providers to inappropriately designate the urgency of cases. Staff has been and will continue to be educated on the requirement to use the designations "stat" and "urgent" appropriately. Periodic review of cases designated "stat" and "urgent" will be implemented to assure compliance. Results from these reviews will be reported at the Medical Staff Executive Committee. As stated in Recommended Improvement Action 8 c, the pulmonary and radiology clinical staff will develop a fast tracking process for diagnosis and management of suspicious lung lesions. Timeliness and ongoing monitoring will be reported to the Medical Staff Executive Committee. This process will then be shared throughout VISN 8.

Recommended Improvement Action(s) 6. The VISN Director, in conjunction with the Medical Center Director needs to:

- c. Take actions to ensure that Radiology Service develops workload and performance standards so that assets may be appropriately managed.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

The workload and performance standards for radiology will be managed by measuring the number of Relative Value Units (RVU) that each radiologist has read over a selected period of time. The Radiology Assessment Report developed by Dr. Charles Anderson, Director, Radiology Program outlines a methodology for assessing productivity for radiologists. The RVU method for studies that he recommended has been and will continue to be used at Bay Pines VAMC until VHA-wide specialty physician productivity standards are implemented. Monitoring the productivity of the radiology staff will be accomplished using RVUs similar to the table included in OIG report.

Recommended Improvement Action(s) 6. The VISN Director, in conjunction with the Medical Center Director needs to:

- d. Ensure that Radiology Service quality improvement plans encompass the interpretation of x-rays performed under contract.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

A program of quality monitoring of x-rays performed under contract will be incorporated into the Radiology Quality Improvement Program. The methodology will consist of blind over-reads of random x-rays from contractors. This will be accomplished once a week by rotating the assignment among the radiology staff. The results of the review will be reported regularly to the Medical Staff Executive Committee.

Clinical Leadership Did Not Ensure Timely Neurosurgery Access

Recommended Improvement Action(s) 7. The VISN Director should ensure that the BPVAMC Director establishes a clear and effective referral mechanism for obtaining timely inpatient, outpatient, and emergency specialty and subspecialty service consultation for specialties not inherent to the facility.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

The specialties not inherent to the facility that consistently have shown a need for increased access are neurosurgery and cardiac bypass surgery. MOUs have been developed with private hospitals and provider groups to provide needed services in a timely and high-quality manner. BPVAMC has forwarded an MOU for consideration with local neurosurgical emergency services at Morton Plant Hospital and Northside Hospital. Also under development is a plan to develop an MOU with local ambulance services to expedite transfers to local facilities for emergency neurosurgical care. The ambulance service has agreed to respond with the closest available unit.

To obviate the need for outside consultations, a neurosurgeon was selected to provide on-site care effective July 31, 2004. A decision tree for transfer of emergent and urgent neurosurgical cases was developed during a meeting with the clinical leadership from BPVAMC and Tampa VAMC and has been implemented. An agreement is being established with Miami VAMC to provide consultation clinics at Ft. Myers OPC. All emergency specialty and subspecialty service consultation for specialties not inherent to the facility are being evaluated to determine the timeliness of service. A neurologist has been hired for the Ft. Myers OPC.

Pulmonary Service Did Not Provide Timely and Adequate Services

On April 14-15, 2004, a comprehensive site visit was conducted to evaluate pulmonary, critical care medicine, and sleep programs.

Recommended Improvement Action(s) 8. The VISN Director should ensure that the BPVAMC Director:

- a. Clearly enunciates the priority of patient care over possible competing endeavors to ensure that veterans receive timely appropriate care.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

The staff of clinical specialties that have potential conflicts, such as research and education, that could affect timely care delivery for veterans, has been educated that veteran healthcare services take priority over other endeavors. During clinical and administrative staff meetings, all staff will be continually reminded that timely and appropriate veteran patient care must always come first. Efforts are underway to separate research clinic activities from veteran healthcare clinics and activities. The BPVAMC Director will certify completion of this relocation to the VISN Director. It will be monitored by the BPVAMC Director on a monthly basis and reported to the VISN Director once established.

Recommended Improvement Action(s) 8. The VISN Director should ensure that the BPVAMC Director:

- b. Reinforces physician staff time and attendance requirements and require each physician to certify that they are aware of VA policies on the granting of leave and days off.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

All physician staff will be sent the most recent copy of time and attendance policies to refresh their understanding of time in attendance requirements. Each physician will be required to sign receipt and understanding of the current policy on time and attendance. Currently, VISN 8 and BPVAMC have a robust monitoring program for part-time physician time and attendance. In May 2003, the VISN 8 Compliance Officer was charged with developing an oversight and monitoring program for part-time physician time and attendance. VACO revised their monitoring process of part-time physician time and attendance in April 2004. At that time, VISN 8 adopted the VACO program for monitoring. This program will be expanded to include all physician staff.

Recommended Improvement Action(s) 8. The VISN Director should ensure that the BPVAMC Director:

- c. Develops a process to ensure timely diagnosis of suspicious lung lesions.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

The pulmonary and radiology clinical staff will develop a fast tracking process for diagnosis and management of suspicious lung lesions. Timeliness and ongoing monitoring will be reported to the Medical Staff Executive Committee, requirements for which will be determined as part of the process development. This process will then be shared throughout VISN 8. Staff will be reeducated to the fact that the primary care practitioner is the coordinator of patient care and is responsible for ensuring timely care coordination for their patients. A nurse case manager will be recruited with a primary responsibility for ensuring timely and appropriate management of cancer patients.

Ineffective Management of Patients Requiring Sleep Studies

Recommended Improvement Action(s) 9. The VISN Director should ensure that the Medical Center Director establishes practice guidelines to ensure that patients receive timely and appropriate consultation when a sleep disorder is suspected.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

An entire Sleep Disorder Section with responsibility for timely and appropriate sleep consultations has been created under the leadership of a sleep disorder certified pulmonologist. The pulmonary service will implement practice guidelines for appropriate referrals for sleep disorders. Systematic processes are being developed to assess the appropriateness of consultations for these services.

Cardiology Service/Cardiac Catheterization

Recommended Improvement Action(s) 10. The VISN Director, in conjunction with the Medical Center Director should ensure that the BPVAMC Critical Care committee oversees quarterly scheduled drills that test the transfer system of critically ill patients from the cardiac catheterization laboratory to a local hospital with which the facility has a cardiac surgery support agreement.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation in principle.

If the frequency of transporting patients by ambulance to a non-VA facility drops below two times a quarter, a mock drill will be conducted. One ambulance drill has been conducted since the beginning of the cardiac catheterization interventional program began. Patients are often sent for open-heart cardiac procedures. Therefore, these transfers will be monitored for timeliness. Ambulance reports for patients who are transported will be monitored for timeliness.

Dermatology Service Procedure Room Did Not Meet Environmental Standards

Recommended Improvement Action(s) 11. The VISN Director should ensure that the Medical Center Director:

- a. Completes an environmental risk assessment for minor dermatology procedures performed in the portable trailer, and takes action to ensure those procedures are performed in an approved setting.

VISN 8 and BPVAMC Comments. VISN 8 partially concurs with this recommendation.

Dermatology procedures are performed in a portable trailer, as no other alternative is immediately available. VISN 8 will conduct an environmental risk assessment to determine the acceptability of this location for patient care. In the next 30 days, the VISN 8 Patient Safety Officer and the VISN 8 Safety Officer will conduct this environmental risk assessment. If action is required, the VISN safety staff will work with BPVAMC leadership to implement an appropriate action plan.

Recommended Improvement Action(s) 11. The VISN Director should ensure that the Medical Center Director:

- b. Establishes a system to identify and track dermatology post-procedure complications.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

A systematic process is in place whereby the staff dermatologist monitors the pathology results of the Dermatology Service. The Chief, Medicine Service will be required to develop and monitor a process to include this quality monitor. This will be accomplished within the next three months. This process will be reported to and monitored by the Operative and Invasive Committee on a quarterly basis as a quality measure. The BPVAMC Operative and Invasive Committee will identify and track dermatology post-procedure complications. The results of this tracking will be reported to the Medical Staff Executive Committee on a regular basis.

Medicine Service Did Not have a Peer Review Process to Monitor Patient Care

Recommended Improvement Action(s) 12. The VISN Director should ensure that the Medical Center Director takes steps to institute a peer review process in all BPVAMC clinical services.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

A hospital-wide peer review committee exists to oversee the peer review process. Its responsibilities are being reinforced and improved, and it will report to and involve the Chief of Staff and the Director. In addition, there are service-level peer review committees within Surgery, Medicine, and Mental Health & Behavioral Sciences Services that encompass active peer review processes. VISN 8 is awaiting the final VHA Directive on peer review in VHA healthcare facilities. This policy will be implemented in clinical care programs throughout VISN 8. In the interim, the existing draft will be used to drive a more robust peer review process at BPVAMC.

ISSUE 6: MANAGEMENT OF SUPPLY, PROCESSING, AND DISTRIBUTION ACTIVITIES

Conclusions

Recommended Improvement Action(s) 18. The VISN Director needs to:

- a. Take appropriate administrative actions against responsible managers for not taking timely actions to preclude surgical work stoppages, inadequate site preparations for conversion to Core FLS, and procurement disruptions and irregularities.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

VISN 8 will take appropriate administrative action.

Recommended Improvement Action(s) 18. The VISN Director needs to:

- b. Review the appropriateness of the contractor representative's purchases from his own firm, whether actions should be taken to see reimbursements for any overcharges, and ensure all other purchases made from the blanket PO were appropriate and accounted for.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

Action by VISN 8 is pending the completion of a separate on-going OIG review of this issue.

Recommended Improvement Action(s) 18. The VISN Director needs to:

- c. Take appropriate administrative actions against employees that violated security password and Government Purchase Card procedures.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

Action by VISN 8 is pending the completion of a separate on-going OIG review of this issue.

Recommended Improvement Action(s) 18. The VISN Director needs to:

- d. Strengthen leadership in SPD by recruiting a proven leader as the Chief, and filing all vacancies.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

On March 1, 2004, Mr. Joel Morrill was detailed to the BPVAMC to work as the acting Chief of SPD to assist in problem resolution. In May 2004, BPVAMC hired Mr. Joel Morrill as the new Chief of SPD. He has ten years experience as the Chief of SPD at the Tampa VAMC. To date, all key leadership vacancies in SPD have been filled. These include prep room supervisor and evening shift supervisor. In addition, work leaders have been identified in the prep room area. Currently, BPVAMC is in the process of orienting all new staff and recruiting additional staff. SPD was organizationally realigned from Acquisition and Materiel Management Service to Nursing Service. An OR nurse coordinator has been assigned to work with SPD to ensure that case carts pick lists and instrument set changes are updated regularly.

Recommended Improvement Action(s) 18. The VISN Director needs to:

- e. Develop and implement policies and procedures for managing SPD that are proactive, based on VA standards and regulations, and are made available to applicable employees.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

Policies and procedures consistent with the requirements of VA Handbook 7176 (SPD Handbook) have been established and implemented. Each employee has been given a copy of the SPD Handbook. Employee performance consistent with the requirements of the SPD Handbook is monitored on a daily basis. Performance indicators have been established to monitor the outcomes of service as part of the SPD Performance Improvement Plan. As part of this process, surgeon and OR nurse surveys are completed on an ongoing basis. Data from these surveys are analyzed, trended, and used to identify performance issues. Corrective action is taken immediately upon problem identification. SPD policies and procedures are updated and added as needed to reflect changes in practice.

Recommended Improvement Action(s) 18. The VISN Director needs to:

- f. Improve security of the SPD stockroom and other inventory areas by restricting access, and obtain surgical case carts that can be adequately secured.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

Case cart items have been isolated to a single area. The SPD area has been locked and access has been limited to SPD employees and the nursing supervisor. Automatic doors have been installed. A new card swipe system will be installed as part of this construction project. Custom made case carts with locking devices have been ordered. The new carts were received and put in use July 21, 2004.

Recommended Improvement Action(s) 18. The VISN Director needs to:

- g. Perform a wall-to-wall inventory of SPD and conduct annual inventories of all stock items.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

An inventory of SPD is currently being conducted. Data corrections are being made during the inventory process so that data validation is integral to the inventory process. A schedule for cyclical and annual inventories is under development. Additional computer terminals have been located in SPD to facilitate the use of automated inventories. A wall-to-wall inventory is scheduled to start within the next 30 days.

Recommended Improvement Action(s) 18. The VISN Director needs to:

- h. Ensure that mandatory inventory management systems are fully used to maintain control over inventory stock and avoid excess purchases.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

Employees have been trained in the use of VA-mandated automated inventory management systems. SPD ensures that all items are properly labeled and scanned into the Dynamed System. Inventory levels are set and are constantly evaluated to meet patient care needs. Process completed on July 28, 2004. After Secretary Principi made a decision to recall the CoreFLS project at Bay Pines, a work group was established to determine if continued use of Dynamed is still possible, since it is the consensus that Dynamed is superior to GIP. Maintenance of that system involves writing the necessary interfaces with VISTA. The team hopes to know by early September 2004 if that is possible. If a Dynamed/IFCAP interface ultimately cannot work, or if VA decides against adopting Dynamed as a business tool of the

future for VA, the Bay Pines VAMC will revert to the pre-CoreFLS process, including IFCAP, until such time as GIP can be built from the ground up at Bay Pines.

Recommended Improvement Action(s) 18. The VISN Director needs to:

- i. Ensure that SPD employees are adequately trained in the use of VA-mandated automated inventory management systems.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

Employee training on automated inventory is being conducted for all SPD employees. Retraining of SPD employees has been completed. The following SPD training sessions have been held and are documented in the employee competency folders.

- SPD Certification
 - Monitoring of liquid oxygen
 - Review of VA Handbook 7176
 - Sterilization Records
 - Proper wrapping of instruments set/peel packing
 - Training on barcode scanner
 - Supervisor training on Dynamed (inventory)
 - Regular meetings with staff to discuss changes and to get staff feedback on any problems or issues.
-

Recommended Improvement Action(s) 18. The VISN Director needs to:

- j. Ensure that SPD inventory records are updated by removing all nonessential inventory line items from the SPD inventory, moving surgical instrumentation to a separate inventory control point, procuring prosthetic items from the appropriate control point, verifying all vendor file information is complete and accurate, verifying that resource objectives and reorder points are correct for all SPD inventory line items, and correcting quantity discrepancies.

VISN 8 and BPVAMC Comments. VISN 8 concurs with this recommendation.

A dedicated FTEE has been reassigned to update and validate all vendor file information to ensure accuracy and completeness. Adjustment of reorder points is ongoing to meet patient care demands. Ongoing clinical coordination and collaboration is used to establish and adjust inventory levels. A performance indicator has been established to monitor the adequacy of inventory levels. Constant communication with users indicates patient care needs are being met. Over 6000 items were listed as SPD inventory. To date, the following has been accomplished.

- 1200 items have been changed to re-process items
- Over 1000 items have been changed to inactive
- Between 500 and 600 items have been identified for possible removal from the SPD inventory
- The value of the SPD inventory has been reduced by \$1million. This was accomplished by identification and elimination of errors in the data.

The Chief of SPD is working with the Warehouse Supervisor to get fast turnover items added to posted stock, which will lower SPD inventory on hand.

Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 6, 2004

From: Acting Assistant Secretary for Management

Subject: **Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)**

To: Assistant Inspector General for Auditing (52)

1. Office of Management (OM) staff have meticulously reviewed the subject report; attached are our comments. I accept your recommendations.
2. The Office of Management is committed to resolving the issues noted in the report. Since the interim report was issued in March 2003, OM has assessed the situation and is aggressively implementing measures to correct existing deficiencies.
3. Thank you for the opportunity to review the draft report. Please contact me if you have any questions about this response.

//s//

William A. Moorman

Attachment

Issue 3: Contracting Procedures and Related Issues

Findings

BearingPoint Received 23 (and 14 modifications) Task Orders Non-Competitively Totaling \$116.5 million. (Pages 44-49)

RESPONSE: In 1999, Federal Acquisition Regulation (FAR) Part 8 mandated that executive agencies use the Federal Supply Schedule (FSS) Multiple Award Schedules (MAS) contracts program for the acquisition of commercial software for core financial systems and for the acquisition of services and support related to the implementation of such software. The regulation required that the contracting officer announce the agency's requirements in a letter of interest to all contractors participating in the FSS MAS contracting program. In late 1999, VA published its letter of interest or white paper, "Integrator IFMS," in FedBizOpps. In that publication, VA outlined the process that would be used to select an integrator and the evaluation criteria. VA further informed industry that the firm selected using this acquisition strategy would serve as VA's implementation partner on this project. VA then identified those firms most qualified to perform this effort through the use of oral presentations. Those firms were invited to submit a written technical proposal and a pricing proposal. It was envisioned that additional task orders would be awarded to the winner of this competition until the project was fully functional. VA believed, in a developmental project such as CoreFLS, utilizing a single integrator through the life of the developmental effort was the most desirable acquisition strategy.

Blanket Purchase Agreement Discounts Valued at \$19.1 million were not pursued. (Pages 49-51)

RESPONSE: The cost proposal incorporated into task order 101-G07037 provided a discount schedule for Phase IV based on the establishment of a BPA for the full suite of integration services. Phase IV as defined in the statement of work consists of prototyping and implementation of the enterprise-

wide application. BPA # VA 101(93) BPA-4338D was signed on April 27, 2000.

The IG's rationale has merit as we can find no evidence that the contractual language in the task orders with regard to phasing was ever revised.

The Office of Management (OM) will review all the task orders and have the project personnel identify work that has been accomplished as part of Phase IV activities. Once that is accomplished, our contracting office will retroactively negotiate discounts to which the government is entitled.

Technical evaluations were inadequate or Nonexistent. (Page 55)

RESPONSE: The program office viewed all proposal submissions. In the spirit of the Federal Acquisition Streamlining Act, and as required by the FSS contract, a streamlined technical review was conducted. However, there is ample room for improvement

OFFICE OF MANAGEMENT

Action Plan

OIG Draft Report

Issues at VA Medical Center Bay Pines, Florida and

Deployment of the Core Financial and Logistic System

(CoreFLS)

ISSUE 3: Recommended Improvement Action(s) 13. The Assistant Secretary for Management should:

a. Take appropriate administrative action against responsible CoreFLS management, contracting personnel, and other team members

Concur.

Goal: To take appropriate administrative action concerning responsible CoreFLS management, contracting personnel, and other team members.

Strategy: OM has initiated administrative actions against the following staff:

1. The Director of Acquisition Operations has been reassigned and further action may follow.
2. The Director of CoreFLS has been reassigned and further action may follow.
3. The initial contracting officer's warrant has not been re-certified.

OM, in conjunction with the Office of the General Counsel, will review information presented in the IG's final report to determine if additional staff sanctions or administrative actions are warranted.

- b. Initiate a review of all payments to BearingPoint to determine whether there were any improper or erroneous payments for collections.

Concur.

Goal: To evaluate all payments made to BearingPoint against task orders for this project.

Strategy: Since March 24, 2004, the Office of Business Oversight (OBO) has been conducting a financial review of the CoreFLS project. Upon receipt of the OBO final report, OM will examine all billings against CoreFLS task orders to determine whether VA is due any discounts, refunds or rebates related to this project. If money is due to VA, collection actions will be initiated.

- c. If the discounts offered for Phase IV work and/or the award fee cannot be recovered, take appropriate administrative action against the responsible VA personnel.

Concur.

Goal: To obtain discounts offered for Phase IV work due to VA and/or recover the award fee from BearingPoint as appropriate.

Strategy: OM will review the work completed by BearingPoint and initiate actions to collect any funds due to VA. Based on success of the collection actions, OM will determine, in conjunction with the Office of the General Counsel, whether additional staff sanctions or administrative actions are warranted.

d. Award and administer any future award fee provisions in accordance with FAR and the GSA contract provisions, in addition to specifying criteria for evaluation of performance

Concur.

Goal: To develop and improve the use of award fees in Department contracts as a way to identify and reward superior performance.

Strategy: Draft guidance that will explain and elaborate on the Department's award fee policy, providing examples and dealing with practical concerns, is being prepared and will be issued for review and concurrence by the end of August 2004.

Concerning the broad issue of contract management, specific measures have been implemented to resolve deficiencies.

March 24, 2004---At the request of the DAS/A&MM, the Acting Director of the Office of Business Oversight began a financial review of the CoreFLS project. This review is ongoing.

March 26, 2004---A formal internal review of Acquisition Operations Service was completed, identifying deficiencies in management oversight and contract development.

March 31, 2004---Due to deficiencies noted in the CoreFLS contract files, a memorandum from the DAS/A&MM was issued to the Acting ADAS for Acquisitions directing that a plan of action be developed to address contract/file documentation in Acquisition Operations Service, paying

immediate attention to current major contracts, including CoreFLS. A plan was submitted on April 2, 2004.

April 2, 2004---Memorandum from the DAS/A&MM to the Acting ADAS for Acquisitions was issued requiring that a comprehensive acquisition process improvement plan for Acquisition Operations Service be submitted for approval by April 16, 2004. The plan was approved with modifications on April 15, 2004. Additional modifications to the plan were made on May 18.

April 7, 2004--- Memorandum from the DAS/A&MM to the Acting ADAS for Acquisitions was issued to establish a CoreFLS contracting team. The composition of that team, which includes a member from OGC and OA&MM technical review staff, was approved by the DAS/A&MM on April 14, 2004.

April 16, 2004---The Director, Acquisition Operations Service, was reassigned. A new Acting Director has been named.

April 20, 2004---Contracting officers were reassigned to implement the improvement plan requirements and to constitute a quality assurance program. This entails reviewing contract files, developing SOPs (two developed to date), and providing guidance on proper implementation of current contract requirements.

May 18, 2004---Acquisition Operations Service began development of an “assignment” database and an “award” database to provide continuous tracking of active requirements and existing contract actions.

June 3, 2004---Approval was granted to hire three new contracting officers in Acquisition Operations Service.

June 8, 2004---A memorandum from the Acting ADAS for Acquisitions directed all OA&MM contracting activities to require technical and legal review of certain task orders, BPAs, and other contract actions which had heretofore not required such reviews. This action was taken as a result of an internal assessment. A formal information letter has been

developed (which is currently in the concurrence process) that will prescribe such reviews for all VA contracts.

July 8, 2004---An agreement with the Office of General Counsel and the DAS/A&MM was reached that would physically relocate a staff attorney to work on Acquisition Operations Service issues and contracts. The staff attorney will remain an employee of OGC but will be reimbursed by OA&MM. This arrangement is intended to ensure timely legal review and to also forge a collaborative relationship with this attorney, i.e., legal advice will be sought during the development of acquisition strategies and throughout the contracting process.

OM has taken action to improve the acquisitions being conducted by the Acquisition Operations Service, and efforts to ensure continuous improvement are underway. On April 15, 2004, we provided OIG staff documentation for all remedial actions taken prior to that date. Subsequent to that date, we have provided and/or informed OIG staff of remedial actions as they occurred. Additionally, we will be establishing a dialogue with the program office in which we will be discussing a method for providing invoices to the contracting officer and otherwise providing better fiscal controls.

On July 21, 2004, OM met with representatives of the Defense Acquisition University and the Navy Supply Command with a view toward developing an outside review of VA's acquisition program. One of these organizations will shortly be engaged to perform that comprehensive review.

e. Conduct a complete review of all travel vouchers submitted by BearingPoint since commencing work in January 2000 to determine if:

- (i) The claimed costs are allowable in accordance with the provisions of the Joint Travel Regulations;
- (ii) Coordinate findings with the Office of Inspector General;
- (iii) Collect any amounts found to be in excess of those allowable under regulations,

(iv) Clarify return home allowable expenses

(v) Check rebates

Concur.

Goal: To review all travel vouchers submitted by BearingPoint since commencing work in January 2000.

Strategy: OM will conduct a review of billed travel expenses to determine whether VA is due any refunds or rebates related to travel expenses attributed to this project. A plan of action with milestones has been formulated to review all travel vouchers submitted by BearingPoint. To the extent possible or applicable, OM will use the Federal Travel Regulations (FTR) as a guide when reviewing billed travel expenses.

All claims for reimbursement of travel expenses will be properly itemized, accompanied by the receipts and other back-up documents. OM will coordinate with the Office of the Inspector General to ensure that the OIG is aware of our progress on the review and validation of allowable expenses and that we are meeting the planned milestones. OM will also report the findings of the review and report the amount of overpayment and the status of the collection action.

Additionally, the contractor will be required to submit a more detailed travel plan with each task order cost proposal. This travel plan will indicate the name of the traveler, the locations (to and from), dates of travel, the purpose of the travel, and that the estimated costs are in compliance with the FTR as applicable.

Issue 4: Deployment of CoreFLS

Findings

VA Management Did Not Implement Prior Recommendations (Pages 78-79)

RESPONSE: Since the interim report was issued, considerable progress has been made on implementing Independent Verification and Validation (IV&V) recommendations.

1. As of the date of this response, 9 of the 14 Access Systems recommendations identified in the April 30, 2003, IV&V report are complete, and 16 of the 21 recommendations identified in the September 30 IV&V report are complete. Attachment 13 of this response provides a detailed status of each report recommendation from a CoreFLS perspective.
2. CoreFLS IV&V findings are now logged into the CoreFLS Issue and Risk Tracking System (CIRTS) for high visibility on a recurring basis. CIRTS issues are reviewed daily and discussed weekly. In addition, associated risks are monitored and tracked to closure.
3. The project team has made progress in completing feasible IV&V recommendations and continues to address CoreFLS issues and risks throughout “stabilization” activities. The current status and progress of risks can be found in CIRTS: <http://vaww.coreflsworld.aac.va.gov/issuerisk/>.
4. In regard to the Independent Security Test and Evaluation Report, the project team is working on preparing a master project plan to address all the security requirements necessary to meet Full Authority To Operate requirements. Also, Access Systems worked with the security team to meet the schedule of key milestones dates.

We agree with the OIG on the need for the IV&V operation to be independently funded and managed. To ensure objectivity and project oversight for cross cutting projects the size and complexity of CoreFLS, we recommend that the IV&V contractor report directly to the Deputy Secretary as the Chief Operating Officer for VA.

Fiscal Services Could Not Reconcile Accounts (Pages 81-83)

RESPONSE:

1. Progress has been made in the development of reports to assist Fiscal Service in account reconciliation, but additional work is required.
2. The decision to not run a parallel operation resulted from the review of the two JFMIP white papers discussing parallel system processing. In particular, the guidelines presented in

the JFMIP white paper, “Financial Systems Data Conversion Considerations,” dated December 20, 2002, were used to determine whether to implement CoreFLS in a parallel environment. According to the white paper, parallel operation “is expensive and only desirable in limited, special cases: when there is a need to retain detailed legacy data to support specific legal requirements or critical transactions that can only be captured in the legacy system. Also this may be an appropriate option when business processes have changed and produce different data or when quality of data in the legacy system is suspect.”

Although business processes changed in CoreFLS and produced different data, the cost of parallel processing would have been prohibitive – another key consideration discussed in the JFMIP white paper “Parallel Operation of Software: Is it a Desirable Transition Technique?” dated October 24, 2001. The second white paper discusses four factors affecting the feasibility of parallel operations that should be taken into consideration. This feasibility analysis specifically discusses: (1) Can the two systems even be compared? What is the degree of similarity and difference in functionality, processing, and data between the legacy and the replacement system(s)? (2) Is the full scope and workload of the parallel test known and cost-effective? (3) Is reconciliation expected and attainable? and (4) Is there discipline to complete the parallel operation as planned?

OFFICE OF MANAGEMENT

Action Plan

OIG Draft Report

Issues at VA Medical Center Bay Pines, Florida and

Deployment of the Core Financial and Logistic System

(CoreFLS)

ISSUE 4: Recommended Improvement Action(s). The Assistant Secretary for Management needs to:

a. Ensure all facilities have certified the reliability of their existing legacy systems, and accuracy of the data, to ensure conversion problems encountered at BPVAMC will not reoccur at other sites.

Concur.

Goal: Ensure all facilities have certified the reliability of their existing legacy systems and accuracy of the data.

Strategy: Develop a process that includes an independent assessment of the legacy system data prior to the station converting to the new systems.

The following steps have been planned or have already been taken that will affect any potential future rollouts:

1. CoreFLS conversion activities include a detailed reconciliation process designed to support and validate the accuracy of legacy financial data, and to a limited extent, inventory data (see link for additional details: <http://vaww.va.gov/corefls/implement/FinRecOverview.htm>). These activities consist of evaluations in 17 areas to record and identify conditions where station subsidiary records are out-of-balance with respect to their General Ledger Account balances. The results for Operational Test Phase 1, which began in October 2002, can be viewed at <http://vaww.va.gov/corefls/implement/FinRecStatus.htm>.
2. VistA patches for IFCAP, GIP, and AEMS/MERS have been developed to identify data inaccuracies in those legacy systems. Meetings and detailed briefings for Fiscal, Logistics, and Information Resources Management staffs are used in preparation for installing these patches in the production environment and on the use of facility output for data cleansing. The "VistA Patch" document contains the details of these patches to be used by facilities to conduct data cleansing activities.
3. In conformance with the Joint Financial Management Improvement Program (JFMIP) white paper, "Financial Systems Data Conversion Considerations," dated December 20, 2002, all transactional data is converted into CoreFLS using an automated program interface and is subjected to full

data edits and validations. By concurrently subjecting the conversion data to full data edits and validations, this process validates the configuration of set-up data, business rules, and other defined parameters. As such, conversion errors can be detected and corrected.

4. A more detailed set of conversion processes and procedures have been developed by the CoreFLS project staff. Since the JFMIP white paper provides only basic guidelines regarding financial conversions, the procedures encompass a greater level of detail in all areas identified in the white paper.

5. The extraction of general ledger data from the legacy data is validated back to the legacy standard general ledger account balances. The spreadsheets show the legacy account balances and the mapping to CoreFLS account balances and what is loaded to the CoreFLS general ledger. The resulting legacy trial balances from FMS Annual Close and the Oracle Federal Financials trial balances as a result of conversion activity are validated against each other.

6. Fiscal and logistics staff certify all transactional data conversions having a financial impact. Additionally, in the future, the data conversions for DynaMed surgical packs, vendors, and purchase and travel cards which are representative of reference data will be certified by the appropriate medical center official.

b. Strengthen data conversion procedures and tests to provide reasonable assurance that converted data will provide desired results and require certification of implementation.

Concur.

Goal: Strengthen data conversion procedures and tests.

Strategy: Develop a process that includes not only an independent assessment of the reliability of legacy system data but also an assessment of whether the data will provide the desired results prior to the station converting to the new systems.

c. Ensure all CoreFLS users are adequately trained to test, operate and maintain the system

Concur.

Goal: Ensure all CoreFLS users are adequately trained.

Strategy: Provide extensive face-to-face training sessions where questions can be asked and answered, where problems can be addressed, and solutions provided.

Tie future application access to completion of the training and certification of specific tasks within CoreFLS.

A VA-wide training work group was formed to provide recommendations on a “go forward” training strategy. An invitation was extended to all known training entities within VA to participate. Comments were received from VHA on the revised training approach.

d. Develop and implement a process to address findings and recommendations reported by Access Systems in the September 2003 CoreFLS Build 1.2 Quality Assurance Independent Verification and Validation Report, the April 2003 CoreFLS Build 1.2 Quality Assurance Independent Verification and Validation Test Results, and the August 2003 CoreFLS Certification and Accreditation Independent Security Test and Evaluation Report.

Concur.

Goal: Develop and implement a process to address findings and recommendations reported by the IV&V contractor.

Strategy: CoreFLS has implemented a process using CIRTTS to address findings and recommendations reported by Access Systems. To date, this process has provided more visibility of IV&V findings among the CoreFLS Project Team. Also, as part of the proposed Help Desk/CIRTTS tracking process, QA production findings will be logged with the Help Desk.

e. Ensure the Independent Verification and Validation process is independently funded and report to a VA organization outside the Assistant Secretary for Management.

Concur.

Goal: Ensure the IV&V process is independently funded and that it reports to a VA organization outside of the office responsible for developing the system.

Strategy: Changes to the current IV&V reporting structure and budget will require VA management direction. In response to Issue 3, we have suggested such reporting might be to the Deputy Secretary.

f. Develop and implement a performance measurement process that will provide VA with an accurate measure of end-to-end response times and delays.

Concur.

Goal: Develop a performance measurement process that monitors end-to-end response time for transactions and navigation activity within the Oracle, Maximo, and DynaMed applications as well as the Data Warehouse and CoreFLS training portal. The performance solution should also monitor performance within the Web, application, and database components to identify specific issues as they occur.

Strategy: Continue efforts to improve the performance management solution (I3 by Veritas). To date, the product has been installed but not fully configured.

Address performance management requirements with the implementation of an upcoming release of the I3 tool.

Develop a project plan for the configuration, upgrade, and implementation of I3 by Veritas.

g. Develop and implement procedures to test system interfaces and validate results to ensure data moves effectively among all applicable systems.

Concur.

Goal: Implement procedures to test system interfaces and validate results to ensure data moves effectively among all applicable systems.

Strategy: Develop a review and certification process to ascertain that all in-scope interfaces have occurred and that data is successfully and accurately being moved between systems.

Design and develop improvements to existing CoreFLS interface coding as requirements are redefined with system owners and help desk tickets are reported.

Implement updated internal interface/integration testing procedures for CoreFLS releases beginning in August 2004.

Assign additional resources to the interface/integration testing effort.

h. Resolve all fiscal reconciliation issues and ensure there are adequate checks and balances between A&MMS and Fiscal Service obligation processes.

Concur.

Goal: Resolve fiscal reconciliation issues and ensure there are adequate checks and balances between A&MMS and Fiscal Service obligation processes.

Strategy: Maintain separation of duties requirements but provide Bay Pines Fiscal staff the capability to close purchase order lines in order to release funds back to the control points.

Bay Pines VAMC Fiscal staff will review two remaining reports, the F50D - Undelivered Orders Report and the F51D VA Verification of General Ledger Balances - Payables (Federal/non Federal) to determine if any purchase order out-of-balance conditions continue to exist. August is the expected target date for this report to be considered usable and reconcilable.

Comments

**Department of
Veterans Affairs**

Memorandum

Date: **AUG 03 2004**

From: Assistant Secretary for Information and Technology (005)

Subject: Response to Office of Inspector General (OIG) Draft Report, EDMS 276903

To: Assistant Inspector General for Auditing (52)

1. We have reviewed the OIG Draft Report on Issues at VA Medical Center Bay Pines, Florida, and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS).

2. We appreciate the opportunity to provide comments on this report. Comments on those recommendations pertaining to Office of Information Technology (OI&T) activities are contained in the attachment.

3. Any questions about the OI&T response may be directed to my office at 273-8842.



Robert N. McFarland

Attachment

VA FORM 2105
MAY 1980

Office of Information and Technology (OI&T) Responses to the OIG Draft Report: Issues at VAMC Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)

Issue 3: Contracting Procedures and Related Issues

Recommended Improvement Action(s) 14. The Assistant Secretary for Information and Technology should:

a. Not award Bearing Point or any other vendor any task orders for CoreFLS integration after the current task order expires June 30, 2004.

OI&T Comment: Bearing Point and any other contractor associated with CoreFLS integration will be given minimum task orders and only those requiring their participation in the stabilization effort and the transition back to the previous financial management software. This approach was vetted with the Secretary and the Inspector General.

b. If CoreFLS is to be continued, develop a comprehensive SOW for the integration effort, considering all of the “lessons learned” to date, and compete the requirements.

OI&T Comment: The focus is presently on the transition back to the previous financial management software. To determine the road forward, the Secretary has established a board of directors, chaired by the Assistant Secretary for Information and Technology and made up of VA’s senior leadership, to examine the results of the CoreFLS pilot program at Bay Pines and make recommendations to Secretary Principi regarding the program's future. CoreFLS was intended to comply with a 1996 federal law that required all governmental agencies to integrate their financial management systems based on commercially available, off-the-shelf programs.

c. Determine a suitable candidate, other than the current CoreFLS Acting Project Director, to be the contracting officer’s technical representative (COTR) for the CoreFLS

requirements. This individual should possess the technical expertise to properly monitor performance.

OI&T Comment: Once a decision has been made as to the future viability of CoreFLS, using lessons learned and the recommendations of OIG, a COTR will be selected to meet the requirements of this item.

d. Take action to ensure that all non-VA employees have the appropriate security clearance process initiated before they are allowed to work on the CoreFLS project, if it is continued.

OI&T Comment: Concur.

Issue 5: CoreFLS Security Controls

Recommended Improvement Action(s) 17. The Assistant Secretary for Information and Technology should ensure that the CoreFLS Project Director improves CoreFLS security controls by:

a. Reducing production access privileges to ensure proper segregation of application developer, system administrator, and security administrator duties.

b. Fully developing and testing procedures to ensure roles and responsibilities are assigned to users based on access criteria.

c. Developing a contingency plan in accordance with NIST 800-34 and ensuring that testing is conducted on contingency-related items to ensure continuity of operations in the event of a disruption of services.

d. Developing and implementing procedures to monitor and log high risk user activity and log user access.

e. Implementing Configuration Control Board (CCB) procedures to help ensure program modifications are properly authorized, tested, and approved.

- f. Identifying and reviewing all prior changes made by contractors with incompatible duties to ensure the integrity of codes, configurations, and data.
- g. Documenting the software extensions and other major modifications to track the applicability of these changes to any new releases of the baseline software.
- h. Ensure software issues are reviewed and comply with all applicable technical requirements.

OI&T Comments: OI&T concurs with the recommendations made above which will be addressed while CoreFLS continues to operate as part of the transition back to the previous financial management software.

The certification and accreditation (C&A) process that the CoreFLS project has nearly completed, through the C&A review function provided by OCIS, has afforded OI&T the opportunity to provide advice, assistance, and guidance on the degree of compliance that this project demonstrates in its implementation of security controls.

Since September 2003, when the CoreFLS C&A package and request for a Full Authority to Operate (FATO) were submitted to OCIS, the CoreFLS project team, in conjunction with OCIS, identified several security control deficiencies which correspond to the OIG recommended improvement action items listed above. Both OCIS and the CoreFLS project team have been actively involved in developing and monitoring a remediation plan to address the deficiencies.

OCIS has not recommended granting a FATO but recently granted an IATO extension for six months (through January 2005) because firm milestones have been established for completion of these outstanding activities. Many of the remediation activities are underway. OCIS will continue to provide oversight on these matters as they impact the C&A process. OCIS staff members have been meeting with the CoreFLS security staff to address high risk areas and to monitor ongoing progress. The high risk areas previously identified and currently addressed in the CoreFLS security risk mitigation plan include:

Activity 1: Institute a CoreFLS security program which includes security risk management, access management, contingency planning, and user provisioning guidance.

Activity 2: Develop an end-to-end user provisioning solution to include password standards, centralized user access administration, and security auditing functionality.

Activity 3: Develop and maintain automated tools to manage end user access rights.

Activity 4: Provide continuous monitoring of CoreFLS security.

Activity 5: Develop a CoreFLS contingency plan strategy to include the development of a Business Continuity Plan, Business Response Plan, Business Impact Assessment, Continuity of Operations Plan, and Disaster Recovery Plan.

Comments

Department of Veterans Affairs

Memorandum

Date: August 3, 2004

From: Acting Assistant Secretary for Policy, Planning and Preparedness

Sub: Office of Inspector General Recommended Improvement Actions

To: Mr. Jon A Wooditch
Deputy Inspector General (50A)

1. The Office of Policy, Planning and Resources and the Office of Security and Law Enforcement has reviewed the recommended improvement actions for the CoreFLS Report. Both offices recommend concurrence for all improvement action items. An action plan for the improvement actions are listed below:
 - a. Include in the VA Directive and Handbook 0710 currently being amended, a requirement for the Office of Cyber and Information Security to be the approving authority for sensitivity designations for non-VA employees with access to VA systems.

Action: The Office of Security and Law Enforcement has made the required change to the Handbook in section 7(e) Investigative Process for Contract Personnel. This Directive and Handbook are currently undergoing the concurrence process. The Deputy Secretary for Security and Law Enforcement requested a one week suspense for the Office of Information Technology (005), Office of Human Resources and Administration (006), Assistant Secretary for Management (004), Office of General Counsel (02) and the Office of the Inspector General. To date, the Office of Security and Law Enforcement has received concurrences by the Office of Information Technology and the Office of Human Resources and Administration. This office does not foresee any reason why the one week suspense will not be met by all outstanding organizations. The Deputy Secretary has relayed the importance of the approval of this Directive and Handbook and all staff offices and organizations are assisting in the completion of the Directive and Handbook.

- b. Initiate the process of including an approval signature block on VA Form 2280 for the Office of Cyber and Information Security approval of the sensitivity designation recommended by VA organization unit sponsoring the non-VA employees.

Action: The Office of Security and Law Enforcement has requested an expedited request to revise VA Form 2280. It is anticipated that the revised form will be completed within the next two weeks.

- . Take interim action to ensure that recommendations 15.a and 15.b are implemented pending the completion of the revised VA Directive and Handbook 0710.

Action: In the interim the Office of Security and Law Enforcement has met with the Office of Cyber Security to ensure that the security eligibility determinations for all non- VA employees are made using the interim guidance of V A Handbook, Section 7(e). The Office of Acquisition Policy Division will also expedite the revision of the Information Letter (IL.) 90-1-6 to reflect the new requirements of security eligibility determinations for non-VA employees.

2. Further questions regarding the content of this memorandum may be addressed to John H. Baffa, Deputy Assistant Secretary for Security and Law Enforcement on (202) 273-5500.

//s//

Gary A Steinberg

OIG Contact and Staff Acknowledgments

OIG Contact	John D. Daigh Jr., MD, CPA (202) 565-8305 Michael L. Staley (202) 565-4625 Daniel Petrole (202) 565-7012
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John Ames
Marc Anderson, MBA
Quentin Aucoin
Dennis Capps
Marisa Casado, RN, MSN
Patricia Christ, RN, MBA
Bertha Clarke, RN
Vickie Coates, MSW, MBA
Sheila Cooley, RN, MSN
E. Marcia Drawdy
Robin Frazier
James R. Hudson
Jay Johnson
George Jordan, CPA
Kelli Kemper
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Nelson Miranda, MSW
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Ken Myers
Rayda Nadal, RN
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