Department of Veterans Affairs

Office of Inspector General

AUDIT OF VETERANS HEALTH ADMINISTRATION EMERGENCY MEDICAL STRATEGIC HEALTHCARE GROUP

Improvements are needed in: determining VA's role in emergency management; staffing; fiscal accountability; interagency financial support; and training and development.

Report No. 9R4-A19-124
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Office of Inspector General
Washington DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to the Under Secretary for Health (10)

Audit of Veterans Health Administration
Emergency Medical Strategic Healthcare Group

1. The Office of Inspector General audited selected aspects of the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) Emergency Medical Strategic Healthcare Group (EMSHG). The audit was conducted at the request of the former Chief of Staff to the Secretary.

2. The purpose of the audit was to determine if: (i) VA's various emergency and disaster-related missions were properly established in legislation, interagency agreements, or other enabling action and were supported by published policies and procedures; (ii) these missions were properly a role for EMSHG; (iii) EMSHG's organization and supervisory structure and its organizational position within VHA served to achieve appropriate mission objectives; (iv) fiscal operations properly accounted for operating expenditures; and (v) management controls over headquarters and field staff were adequate.

3. Based on audit test results, we concluded that there exist several significant issues related to EMSHG management and operations that have impacted staff efficiency and effectiveness. The conditions we identified as problems can be grouped into several categories, as follows:

- Overall mission
- Organization and staffing
- Control of fiscal resources
- Interagency issues
- Training programs
- Top management
- A proposed new mission

4. Fiscal controls were sufficient to identify VA resources consumed in support of disaster relief operations for the purpose of reimbursement from other Federal agencies. However, we found that EMSHG management and staff, and by extension VA, have assumed national emergency and disaster-related duties that are outside VA's primary

purpose of providing medical care and which duplicate functions of other Federal agencies. EMSHG field staff perform duties that could be performed by others or that need not be performed at all. EMSHG staffing exceeds levels necessary to perform essential functions. EMSHG management needs mechanisms to better track and account for operating expenditures. In addition, EMSHG's participation in the National Disaster Medical System (NDMS) annual conference needs to be re-evaluated by VHA top management. Finally, EMSHG's training and development activity needs to be re-evaluated.

5. We recommended that the Under Secretary for Health: (i) determine what VA's role should be with respect to the various Federal Government disaster programs; (ii) adjust EMSHG Headquarters staffing levels accordingly; (iii) eliminate certain field positions and transfer their essential duties to the Veterans Integrated Service Networks (VISNs); (iv) eliminate two specific positions in EMSHG Headquarters; (v) establish accounting mechanisms to track and account for EMSHG expenditures, to identify and permit reallocation of unneeded funds; (vi) determine whether VA should continue to provide financial support to the NDMS annual conference; and (vii) re-evaluate EMSHG's training and development activity.

6. We also identified two issues for which we made no recommendations, but which VHA top management needs to address. These involved: (i) the functioning of EMSHG top management; and (ii) VA's ability to take on a proposed new emergency and disaster-related mission.

7. The Under Secretary for Health concurred with all recommendations, with the exception of a deferred concurrence for the recommendation to eliminate certain field staff and transfer their duties to the VISNs. The deferral for that recommendation is to allow time for a new Chief Consultant for EMSHG to assess the situation. With that one exception, we consider all issues resolved, although we will continue to follow up on all planned actions until completion.

For the Assistant Inspector General for Auditing

(Original signed by)

WILLIAM V. DEPROSPERO
Director, Chicago Audit Operations Division

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RESULTS AND RECOMMENDATIONS

Staff of the Department of Veterans Affairs' (VA) Emergency Medical Strategic Healthcare Group (EMSHG) are charged with fulfilling several mandated missions that relate to VA's response to natural and man-made disasters and to national defense contingencies. EMSHG staff plan, coordinate, administer, or execute VA's participation in:

- The Federal Government's continuity of government program.
- Providing backup medical care for DoD personnel.
- The Federal Response Plan (FRP) for natural and man-made disasters.
- The National Disaster Medical System (NDMS).
- Responding to natural and technological hazards.
- Developing continuity of operations plans for individual VA medical centers.

In addition to these six missions, we were informed during the audit that some Congressional interest existed in tasking VA, and thus EMSHG, with leading a Federal effort to train medical personnel to respond to the potential terrorist use of weapons of mass destruction: chemical, biological, or nuclear.

EMSHG's budget for Fiscal Year 1998 was about $7.6 million. EMSHG has an authorized ceiling of 97 full-time equivalent employees (FTEE). This includes 40 full time Area Emergency Managers (AEMs) and 29 FTEE program assistants (PAs) located at 40 VA medical centers. These medical centers correspond approximately to the 40 Federal Coordinating Centers (FCC) that are staffed by VA as part of its participation in the NDMS. EMSHG also has four staff assigned to a training and development center in Indianapolis, IN and one staff member assigned to the transportation center at Scott Air Force Base, near Belleville, IL. The remaining 23 staff are assigned to EMSHG Headquarters located in Martinsburg, WV.

There Are Several Significant Problems Related to EMSHG Operations That Have Impacted Its Efficiency and Its Effectiveness

Many of these difficulties are the result of historical happenstance, but others have been caused or exacerbated by EMSHG's recent management. The problems we identified can be grouped into several categories. These include problems related to:

- Overall mission
- Organization and staffing
- Control of fiscal resources
- Interagency issues
- Training programs

- Top management
- A proposed new mission

The following sections describe briefly the first five of these broad areas. Additional detail is contained in Appendices III, IV, and V. The last two areas are discussed in detail in a Management Advisory section following the recommendations.

Much of What EMSHG Staff Do Is Not Required by Their Missions

EMSHG has been tasked with six specific missions related to emergency and disaster preparedness and relief at the national and local levels. However, EMSHG staff were performing duties not required by those missions, based on a review of the functions actually performed and on interviews with Public Health Service (PHS), Federal Emergency Management Agency (FEMA), and Department of Defense (DoD) officials. In addition, we concluded that some things that EMSHG staff were doing could be better performed by other VHA staff.

In our opinion, EMSHG's staffing, organization, and philosophical orientation are geared toward "managing" disaster relief efforts as opposed to simply "facilitating" the delivery of VA medical care resources when called upon. To support this assessment, we noted the following:

- EMSHG officials and staff deploy to disaster sites even though they are not, except by coincidence, medical care professionals and have set up or attempted to set up support facilities that duplicated facilities provide by PHS staff.

- Much of the material developed by EMSGH training staff relates more to disaster management techniques and ensuring NDMS functions and resources are available than it does to the medical treatment of disaster victims.

- EMSHG has invested large amounts of money in sophisticated communications equipment to support EMSHG staff deployments.

- EMSHG Headquarters staffing of 24 FTEE is more than twice the size of DoD's equivalent office.

EMSHG's management philosophy has concentrated on disaster management, largely duplicative of FEMA and PHS missions, rather than on delivering the resources called for in EMSHG's six authorized missions. Based on EMSHG's mission, its role should be limited primarily to:

- Identifying and cataloging available VA resources for different disaster scenarios.
- Activating such resources when FEMA and PHS ask for them.

- Arranging transportation for such resources.
- Tracking resource consumption for later reimbursement from FEMA and PHS.

VHA management, in consultation with FEMA and PHS officials and with guidance from the Office of the VA Secretary, needs to assess whether "managing" disaster relief efforts is a proper role for VA, or whether VA's role should be more focused on delivering medical care resources when called upon by other Federal agencies that are specifically tasked with disaster management. If the conclusion is the latter, then EMSHG Headquarters staffing could be significantly downsized.

In addition, based on an analysis of activities actually performed by EMSHG staff, one significant group of EMSHG staff perform tasks that either would be better performed elsewhere in VA or not at all. Most of the tasks performed by EMSHG Area Emergency Managers (AEMs) and their program assistants (PAs) could either be eliminated or transferred as collateral duties to VHA Veterans Integrated Service Network (VISN) staff. AEMs and PAs make up 69 of EMSHG's 97 FTEE.

We found that the major component of AEM and PA duties included tasks related to their assigned FCCs within the NDMS, but which they did not need to perform. According to many AEMs[1], these duties typically included:

- Networking among NDMS member hospitals and local and state government disaster agencies.
- Attending meetings of local and state government disaster agencies.
- Planning for area disasters.
- Planning and coordinating, or assisting in the planning and coordinating, of area disaster drills.
- Keeping up-to-date on NDMS member hospital capabilities

However, these tasks are apparently not consistent with tasks performed by comparable DoD staff who have jurisdiction over other FCCs. We concluded that, in general, only the last task bulleted above is normally required of FCC officials and that, once local hospitals have been brought into the NDMS program, there is little left to do except to occasionally update their capabilities inventory. We based this conclusion on information provided by the DoD official responsible for the FCC/NDMS program in his agency. In DoD, FCC/NDMS activities are a low priority collateral duty, rather than a principal duty. Army staffed FCCs with reservists who may spend about one weekend

[1] *Actual duties among AEMs and PAs varied widely. In fact, most AEMs, some in concert with their local Medical Center Directors and some not, wrote their own position descriptions. In addition, the weight given to the various functions that might appear in AEM position descriptions and the time devoted to each also varied widely. While EMSHG Headquarters staff desired to standardize AEM functions, they lacked the authority to do so. One medical center Director told us that each AEM makes of the job what he or she wants.*

per month on FCC and NDMS duties. Navy and Air Force FCCs use active duty personnel for whom such duties are near their lowest priority.

We also found that some AEMs write their medical center's disaster plans, even though that is a duty traditionally performed by medical center safety officers, especially at facilities that do not have AEMs.

In addition, most AEMs and PAs perform tasks assigned by their Medical Center Directors that do not relate to any of EMSHG authorized missions. For some AEMs this type of work represented as much as 65 percent of their time, and often more for PAs.

Lastly, we found that some AEMs occasionally were deployed to national disaster sites[2] to assist in relief efforts. We question whether deployment to a disaster site is a needed function of an AEM.

Appropriate AEM and PA functions should be transferred to the 22 VISNs. In many cases these functions can be assigned as collateral duties to existing VISN staff. If some VISNs require additional staff to perform AEM functions, the additional staff can be funded from savings derived from eliminating the present 69 FTEE AEM and PA positions, which we estimate at about $4.0 million[3].

Organizational and Staffing Issues Need To Be Addressed

Because of a significant organizational anomaly, EMSHG does not have effective control over most of its staff. We found that EMSHG's officially approved organizational structure was significantly dissimilar to its actual structure. Because its staff are doing work that does not need to be done, EMSHG has more staff than it needs.

EMSHG management does not have effective control over its AEMs and PAs. These staff are reflected in the organizational hierarchy, are paid for from EMSHG funds, and are theoretically subject to EMSHG policies and directives. Nevertheless, they are directly controlled by the Medical Center Directors where they are assigned. This situation has created numerous control problems and conflicts.

- Most AEMs and PAs told us that they believed they worked for their local Medical Center Directors.

[2] *EMSHG Headquarters officials informed us that it was their desire that all AEMs be subject to this occasional duty. However, these same officials admitted that not all AEMs are qualified for this function, and these officials blamed that on their own lack of direct control over AEM development. Consequently, some AEMs have never been deployed and others have been deployed more than once.*

[3] *Besides annual salaries for AEMs ($2,632,341) and PAs ($929,603), this includes over $365,307 for overhead that is paid annually to medical centers to support AEM and PA staff.*

- Many AEMs and PAs performed tasks assigned to them by local Directors that were not related to EMSHG missions or were only marginally related.

- EMSHG management had no effective control over AEM and PA position descriptions. Most AEMs had written their own position descriptions, and these varied widely in content, reflecting local priorities rather than EMSHG mission priorities.

- Although many AEMs traveled extensively and despite funding all AEM travel, EMSHG management had no effective control over that travel. EMSHG management approved neither AEM travel requests, nor their travel vouchers. We identified several cases of questionable AEM travel claims.

- Although EMSHG policies recommended particular training credentials for AEMs, EMSHG management had little effective control and no enforcement authority over AEM training.

- General Schedule grading of AEMs was inconsistent. Of the 40 AEMs, 37 were GS-13 and 3 were GS-14s, although there were no apparent differences in their duties. The three GS-14s were former Regional Emergency Managers who had been displaced when the Medical Regions were dissolved. In addition, during the audit, we were told that one GS-14 was downgraded to a GS-13, and an attempt to downgrade another GS-14 was blocked by a VISN Director.

The present situation is not conducive to the effectiveness or efficiency of VA's emergency and contingency missions. EMSHG management was fully aware of the control problems that the current organization of AEMs and PAs within EMSHG has created. They expressed to us their belief that the solution lay in giving full "ownership" of AEMs and PAs to EMSHG. However, accepting our recommendation to eliminate AEM and PA positions (see the preceding section) and transferring their necessary functions to the 22 VISNs would effectively solve these control problems.

We also identified organizational issues related to EMSHG Headquarters itself. EMSGH Headquarters' organization has, over time, undergone evolutionary changes: staff have been added; the dissolution of the Medical Regions necessitated some staffing adjustments; and supervisory realignments have been made. However, none of these are reflected in EMSHG's current approved organization chart. To address these changes and to attempt to solve the problem of AEM control, EMSHG top management submitted a formal request for a new organizational structure to VHA Headquarters in 1997. This request had not been acted on at the time of our audit.

EMSHG Headquarters staff could be reduced from 7, to as many as 15 FTEE, if EMSHG's basic mission is defined as facilitating the delivery of VA medical care resources to disaster sites, and AEM and PA duties can be transferred to the VISNs. We base this assessment on experience in DoD, on reaction from PHS officials, and on our analysis of 18 non-clerical positions in EMSHG Headquarters. According to DoD officials, EMSHG's equivalent organization within DoD had only about 10 staff. In addition, PHS officials expressed surprise to us when informed of EMSHG's present staffing level. Reducing EMSHG Headquarters staff by 7 FTEE would save about $335,000 in annual salary costs.

In addition, EMSHG Headquarters was overstaffed by two questionable positions, with total annual salaries of about $190,000.

- The Deputy Director was not a true deputy and had few substantive duties assigned.

- The Director, Response Technical Support[4] (GS-14) position was unnecessary. The incumbent was one of four displaced Regional Area Managers, and he continues to function as he had prior to the dissolution of the Regions, i.e., he "supervises" AEMs who would have fallen under the jurisdiction of the former Medical Region 1. No other of the former regions has such a position.

EMSHG Did Not Have Effective Control Over Much of Its Operating Expenditures

The existence of unspent funds at the end of several fiscal years suggested that EMSHG's budget processes could be improved. In addition, VA funds allocated to support NDMS activities were poorly controlled.

Management of EMSHG's funds is completely decentralized among VA Central Office and 41 VA medical centers. There is no central control point within EMSHG for EMSHG's funds; and, only one person at EMSHG Headquarters, a budget analyst, was tasked specifically with keeping track of EMSHG funds. Consequently, EMSHG funds have been difficult to control properly.

Like most all VHA organizations, EMSHG funds begin in VA Central Office, VHA accounts. Quarterly, or more often as needed, funds are transferred to the 41 VA medical centers that support EMSHG operations and staff:

- Funds for EMSHG Headquarters operations are transferred into VA Medical Center (VAMC) Martinsburg, WV fund control points and are expended by medical center fiscal staff on instructions from EMSHG officials.

[4] *The title bears no relation to the assigned duties.*

- Funds for AEM and PA salaries, travel, and supplies are transferred into fund control points at the 40 VA medical centers that support them, and are expended by medical center staff as needed or as requested.

- Funds for EMSHG's Training and Development staff at Indianapolis, IN are transferred into VAMC Indianapolis fund control points and are expended by medical center fiscal staff as needed or as requested. (One of the 40 AEM positions was also supported by VAMC Indianapolis.)

- Funds for one out-based EMSHG Headquarters staff person (the Director, Response Technical Support) are transferred into fund control points at VAMC Lyons, NJ (the incumbent's official duty station), and are similarly handled by that medical center's fiscal staff. (One of the 40 AEM positions was also supported by VAMC Lyons.)

EMSHG management did not adequately monitor expenditures made by supporting medical centers. As a result, approximately $414,000 in EMSHG funds were used in recent years by those medical centers for their own purposes. For example:

- From Fiscal Year 1992 through Fiscal Year 1997, VAMC Martinsburg kept approximately $221,000 in net unspent, end-of-year EMSHG funds for support of EMSHG Headquarters staff.

- In Fiscal Years 1997 and 1998, four medical centers kept about $162,000 in unneeded EMSHG funds. They also kept another $5,500 in VHA funds intended as overhead support for EMSHG staff. These funds were for AEM and PA positions that were either vacant or that were misidentified as to the applicable FTEE.[5]

- In Fiscal Year 1997, 31 medical centers kept approximately $25,400 in unspent, end-of-year EMSGH funds for support of AEMs and PAs.

In addition, EMSHG Headquarters staff did not have adequate control over AEM travel. Even though AEM travel funds were provided from EMSHG budgeted funds, local Medical Center Directors, or their designees, generally approved AEM travel requests and subsequent travel claims. We identified several minor cases of questionable travel by AEMs that might have been prevented had approving officials had a vested financial interest in the expenses incurred by AEM travel.

[5] *In one case, a medical center received EMSHG funds sufficient to pay for a full time PA. However, the medical center was served only by a half time PA.*

Lastly, we found that EMSHG officials did not have effective control over funds used to support NDMS operations. In cooperation with PHS, FEMA, and DoD, VA funds operations of the National Disaster Medical System, primarily for its annual conference. Because NDMS is not an organization with a staff or a budget (it is a "system"), there is no central control point to account for funds from the four agencies for conference expenditures.

Our attempt to audit the expenditure of VA funds to support the 1997 NDMS conference resulted in EMSHG officials being unable to account for $46,490. First, they failed to account for about $8,700 in EMSHG funds intended for expenses related to pre-conference planning, mostly travel to locate and assess conference sites. EMSHG officials were also unable to account for about $33,590 in funds reportedly left over from the prior year's conference that were allocated for the same purposes. Circumstantial evidence suggested to us that both the $8,700 and the $33,590 were probably converted to the use of VAMC Birmingham, AL as unspent year-end money. (However, no interviews or reviews of records could confirm this.) Both amounts were controlled by the Regional Medical Education Center (RMEC) in Birmingham, AL. In addition, another $4,200 in EMSHG funds was spent by the RMEC in error to support medical center participation in the conference[6].

We observed one peculiar transaction related to funds that were collected at the conference from attendees. The funds were collected by a private contractor hired for that purpose and disbursed for conference related expenses such as conference space, audio-visual services, and break time snack foods and drinks. Our review of accounting records provided to us by the contractor revealed that the contractor paid $3,000 to the hotel for one line item called "gratuities." The hotel in turn gave $3,000 in cash to an EMSHG employee who then distributed it to various hotel staff as tips. The only accounting for the disposition of the $3,000 was on informal, handwritten notes.

If EMSHG continues to sponsor or participate financially in NDMS conferences, EMSHG officials should obtain a proper accounting of funds sufficient to satisfy themselves that VA funds were spent as intended. Also, unspent funds should be returned to EMSHG or VHA Headquarters accounts for reallocation prior to year-end. Because other Federal agencies are involved, it may be necessary for EMSHG to negotiate with those agencies regarding acceptable fiscal controls related to NDMS operations.

[6] *EMSHG officials claim not to have authorized payment of medical center incurred costs from its funds.*

VA Is Funding a Disproportionately Large Share of the NDMS Annual Conference

The audit identified serious fiscal issues related to EMSHG's involvement, and by extension, VA's involvement, in the intergovernmental National Disaster Medical System. This related, in particular, to VA's financial participation in the annual NDMS conference. Based on interviews with officials and staff in VA, PHS, FEMA, and DoD the annual conference is of great value to the national emergency preparedness community. However, it appears that VA has, for several years, financed a significant portion of the conference's expenses.

For example, although an old agreement calls for each of the four supporting agencies to contribute about $50,000 annually to NDMS activities (principally the annual conference), we were informed that both FEMA and DoD had, in recent years, declined to contribute their share.

For the 1997 conference, PHS officials told us that they had contributed about $62,500 toward NDMS operations. However, we found no evidence of this in any of the VA, EMSHG, RMEC, or contractor records we reviewed. In addition, PHS's fiscal staff informed us that they could not identify any such contribution. We were also told that the $62,500 might have been used to fund (i.e., pay salary and transportation costs for) PHS speakers at the conference. We are left with the conclusion that VA was probably the only Federal agency that funded any part of the conference from its own resources.

Given the apparent lack of financial commitment from the other three Federal agencies involved in NDMS, in our opinion, VHA top management needs to assess VA's degree of financial commitment to NDMS activities, particularly to the annual conference.

EMSHG's Training and Development Activity Should Be Re-Evaluated

In our opinion, the functions of the organizational component in EMSHG responsible for training and development need to be re-evaluated. EMSHG operates a Training and Development (T&D) group located in Indianapolis, IN, which consists of four full-time staff. This group produces a variety training materials for EMSHG staff.

However, we were unable to identify a clear function for this staff, and we were not satisfied that the work they were doing required four full-time staff. We noted that neither T&D staff, nor anyone else in EMSHG, plans, coordinates, oversees, executes, or monitors AEM and PA training. When asked for the training records of AEMs, T&D staff could not provide any, nor could anyone else in EMSHG provide them. AEMs told us that they go through their medical centers for training. We also noted that, although EMSHG has begun a certification program for AEMs, T&D staff involvement is minimal.

AEMs did tell us that they do receive training materials from T&D staff occasionally, such as training manuals and videotapes. However, some of these same AEMs questioned the value of the material. As one said, paraphrasing, "they sit on my shelves gathering dust." The quality of the material aside, we were unable to determine what the T&D staff do on a day-to-day basis.

If, as we are recommending, EMSHG's overall mission is significantly changed and reduced in scope, there may be a greater role for training and development of non-EMSHG staff in emergency, disaster, and contingency related issues. However, we did not examine whether EMSHG's current T&D staff are qualified to take on that role. At a minimum, T&D operations should be relocated to EMSHG Headquarters. This would allow closer supervision, a better assessment of T&D staff capabilities, and a better integration of T&D functions into whatever EMSHG's mission will become.

Conclusion

EMSHG has several significant problems that have impacted its efficiency that need to be addressed by VHA top management.

Some EMSHG staff perform tasks that would be better performed elsewhere in VA, elsewhere in the Federal Government, or not at all. The most obvious examples of such activities are many that are performed by AEMs and PAs. In addition, EMSHG management philosophy is geared more toward "managing" disaster situations and less toward simply facilitating delivery of VA medical care resources. As a consequence, EMSHG has grown into a bureaucracy that appears to duplicate in large measure important functions of the PHS and FEMA organizations.

EMSHG's officially approved organizational structure is significantly dissimilar to its actual structure. EMSHG management does not have effective control over most of its staff. Because EMSHG employees do work that does not need to be done, it is overstaffed.

EMSHG does not have effective control over much of its operating expenditures. The existence of significant unspent funds at the end of several fiscal years suggests that EMSHG's budget and control processes could be improved. Finally, VA funds allocated by EMSHG to support NDMS activities were poorly controlled.

There are serious fiscal issues related to VA's involvement in the intergovernmental National Disaster Medical System. VA carried an undue financial and resource consumption burden for NDMS operations, principally its annual conference.

Finally, the mission and function of EMSHG's training and development staff should be re-evaluated. The current training and development function is not contributing to EMSHG mission accomplishment

For More Information

- *Additional details about EMSHG's various missions are contained in Appendix II.*
- *Additional details about EMSHG and VA emergency and disaster-related mission issues are contained in Appendix III.*
- *Additional details about organizational and staffing issues are contained in Appendix IV.*
- *Additional details about fiscal issues are contained in Appendix V.*

Recommendation 1

The Under Secretary for Health should:

a. Determine what VA's role in disaster management should be.

b. Adjust EMSHG Headquarters staffing levels accordingly.

c. Eliminate AEM and PA positions and transfer their essential Federal Coordinating Center duties to the 22 Veterans Integrated Service Networks.

d. Eliminate the Deputy Director and Director, Response Technical Support positions in EMSHG Headquarters.

e. Establish accounting mechanisms to track and account for EMSHG expenditures, and to identify and permit reallocation of unneeded funds.

f. Determine whether VA should continue to provide financial support to the annual NDMS conference.

g. Evaluate the need for the EMSHG training and development unit in Indianapolis.

The associated monetary impact for Recommendations 1b., 1c., 1d., and 1f. are shown in Appendix VII.

Under Secretary for Health Comments

The Under Secretary for Health concurred with all recommendations, with the exception of a deferred concurrence for the recommendation to eliminate certain field staff and transfer their duties to the VISNs. The deferral for that recommendation is to allow time for a new Chief Consultant for EMSHG to assess the situation. (The full text of the Under Secretary's comments and implementation plans is contained in Appendix VI.)

Office of Inspector General Comments

The Under Secretary's comments and implementation plans are acceptable, and with the one exception, we consider all issues resolved, although we will continue to follow up on all planned actions until completion.

MANAGEMENT ADVISORY

In our audit of EMSHG operations, we identified two issues that need to be addressed, but for which we have made no specific recommendations. These involve EMSHG top management and the possibility of EMSHG, and VA, acquiring a new, seventh mission.

Top Management Issues

There existed a situation within EMSHG's top management that has caused divisiveness within the organization. This situation has contributed to low morale within EMSHG and to some of the other conditions we noted. In particular, it has contributed to the failure of AEMs and PAs to identify with EMSHG as "their" organization.

EMSHG's Director, or Acting Chief Consultant, displaced the previous Director in June 1993. The previous Director was reassigned to a Deputy Director position and retained his Senior Executive Service (SES) level 2 grade and pay.

During our visits to EMSHG Headquarters, we observed that the Deputy Director performed tasks that were not a traditional deputy's role. He supervised two field AEMs (the only two AEMs who are not supervised by local Medical Center Directors), one other professional staff person (a GS-14), and a secretary. Although he was occasionally given some tasks to perform or projects to complete, he never functioned in a true Deputy Director's role. For example, we observed that at no time during our on-site visits to Martinsburg was the Deputy Director ever in attendance at our meetings with the Director and his other "top staff." In our opinion, the Deputy Director's role at EMSHG had been extremely minimized.

During the audit we interviewed every non-clerical employee at EMSHG Headquarters and several field AEMs and PAs. Through these interviews we observed a significant, and obvious "split" between staff regarding the former Director and his replacement. Attitudes among some staff ranged from sympathy for the former Director to open antipathy toward his replacement. On the other hand, other staff displayed respect for the new Director and little or no respect for the former Director. Only a small number did not express any bias toward one or the other. It was clear to us that the whole organization was radically, and perhaps irreparably, divided in its attitude toward the two managers.

In our opinion, this division cannot possibly be conducive to mission effectiveness. Further, it has been a major contributing factor to the inordinately large number of grievances, EEO complaints, and OIG hotline referrals that EMSHG staff have generated against each other since 1993, some of which have been sustained in whole or in part.

It is our understanding that VHA management is presently recruiting for a permanent Chief Consultant for EMSHG. Assuming that either or both the Deputy Director and the Acting Chief Consultant (the Director at the time of our review) remain in EMSHG, the new Chief Consultant will have to consider this history in much of his or her management decision making.

Seventh Mission

In addition to VA's six specific authorized disaster related missions, a seventh such mission has been proposed for VA. Statements have been made to Congress that VA is capable of leading a government effort to plan for and respond to terrorist use of weapons of mass destruction, including nuclear, biological, and chemical weapons. While VA certainly has medical care resources that could be employed in assisting victims of such weapons, in our opinion, VA officials should be very careful to avoid overstating VA's capabilities in this regard for the following reasons:

- While there are undoubtedly physicians and other health care workers in VA who have knowledge of treatment methods for victims of chemical, biological, and nuclear weapons, these workers have not been identified or inventoried. Whether their numbers, locations, and willingness to be deployed are sufficient is unknown.

- It has not been established that VA has the "institutional knowledge" of the proper response to the use of weapons of mass destruction. Mobilization, transport, deployment, and site application of medical care resources in response to the use of such weapons seems to us to be a kind of expertise that is more likely found in DoD than in VA. In fact, DoD presently has a very active program to train local community officials and others in responding to the use of such weapons.

- VA can cost effectively acquire pharmaceuticals to treat victims of weapons of mass destruction and can store them at strategic locations. However, VA may not have the infrastructure necessary to transport pharmaceuticals directly to a disaster site timely and to administer them in mass quantities.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The purpose of our audit was to determine if EMSHG's various missions were properly established in legislation, interagency agreement, or other enabling action and were supported by published policies and procedures. We assessed whether desired program results or benefits were being achieved. We evaluated EMSHG's organization and supervisory structure and whether its organizational position within VHA served to achieve, efficiently and effectively, mission objectives. The audit also determined if fiscal operations properly accounted for operating expenses and were adequate to account for and collect funds owed VA for use of VA resources in support of emergency relief operation. Finally, we assessed the adequacy of management controls over headquarters and field staff.

Scope and Methodology

The scope of our audit was limited to reviews of documents pertinent to EMSHG's mission, operations, organization, staffing, and interagency activities and agreements. We interviewed EMSHG's headquarters and field staff, staff of other VA elements, and staff of other government agencies that interact with EMSHG. Through our reviews of the documents and interviews we gained an understanding of how EMSHG's operations fit into a variety of interagency emergency and contingency operations and planning. We reviewed travel, training, and fiscal records and various position descriptions and other information relevant to emergency deployments.

We analyzed EMSHG's funds used to help finance the NDMS annual conference. Our audit was limited to a review of the 1997 conference. This phase of the audit required that we obtain additional information and financial documentation from the VA Medical Center in Birmingham, AL to account for NDMS funds and expenditures made by the Birmingham VA REMC.

We also reviewed pertinent documentation and financial information pertaining to two private organizations that provided services for the NDMS conference. We also reviewed the appropriateness of payments made to the hotel where the conference was held.

The audit was conducted in accordance with generally accepted Government Auditing Standards and consisted of such tests as were deemed necessary under the circumstances. No automated data processing information was used to derive our conclusions or recommendations.

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BACKGROUND

The Emergency Medical Strategic Healthcare Group (EMSHG), formally referred to as the Emergency Medical Preparedness Office (EMPO), was established in the mid-1980's. However, according to EMSHG staff, the group was not fully operational with a budget of its own until Fiscal Year 1992. Currently, the organization has an authorized ceiling of 97 FTEE. As of July 14, 1998, EMSHG had 87.5 FTEE on duty (9.5 FTEE vacancies) with annual salaries of about $5,001,525. The projected operational budget for Fiscal Year 1998 was $7.6 million.

EMSHG's authorized ceiling of 97 FTTEE provides for 40 full time Area Emergency Managers (AEMs) and 29 FTEE program assistants (PAs), some full time and some part time. The AEMs and PAs are assigned at 40 VA medical centers throughout the country, which serve as Federal Coordinating Centers (FCCs) in the NDMS. EMSHG also has four FTEE training and development staff located at Indianapolis, IN. One FTEE is assigned at Scott Air Base in Illinois. The remaining 23 FTEE are assigned to EMSHG Headquarters at VAMC Martinsburg, WV.

EMSHG's mission is to provide technical guidance, support, management, and coordination necessary to conduct programs ensuring healthcare for eligible veterans military personnel, and the public during DoD contingencies and during natural, manmade, and technological emergencies. EMSHG staff plan, coordinate, administer, or execute VA's participation in the following six distinct but related missions:

> Continuity of Government — Under Executive Order 12565 supporting the continuity of government program during national emergencies, EMSHG staff maintain a relocation site in Martinsburg, WV and necessary communication facilities for use by VA top managers in the event these are needed during a major national emergency.
>
> DoD Contingencies — Under Public Law 97-174, EMSHG staff maintain data on the availability of VA beds which would be provided to Department of Defense (DoD) personnel during time of war or other emergencies involving military personnel. EMSHG staff would also coordinate the receiving and transfer of DoD patients into the VA system.
>
> Federal Response Plan (FRP) — Under Public Law 93-288, EMSHG staff plan and coordinate VA's participation in the FRP. Under the FRP, VA can be asked to provide engineering services, mass care and sheltering, resources support, health and medical services, and urban search and rescue assistance during disaster

conditions. EMSHG staff may deploy to disaster sites to assist Federal Emergency Management Agency (FEMA) and Public Health Service (PHS) staff and to support any Veterans Health Administration (VHA) clinical staff who may also have been deployed.

National Disaster Medical System (NDMS) — EMSHG personnel staff 40 of the 66 Federal Coordinating Centers (FCCs) that form part of the NDMS. The NDMS is a partnership among VA, DoD, PHS, and FEMA for planning and coordinating the delivery of medical relief by the federal, state, local, and private sectors during and after disasters.

Natural and Technological Hazards — Under Executive Order 12657, EMSHG staff plan and coordinate VA's response to natural and technological hazards (e.g., radiological accidents at nuclear power stations) as part of the Federal Radiological Emergency Response Plan.

VA Contingencies — Through planning and coordination, EMSHG staff help ensure continuity of operations at VA medical facilities during local emergency conditions.

In addition, we were informed during the audit that there existed some Congressional interest in involving VA, and thus EMSHG, in planning for and responding to disasters caused by terrorist use of weapons of mass destruction (nuclear, biological, or chemical).

Over the last several years a significant number of formal grievances and EEO and other complaints have been lodged by, and against, EMSHG management and staff. Because of the nature of these complaints and the investigative results to date, VA's Chief of Staff (00A) requested that we perform an audit of EMSHG's efficiency, operations, organization, and personnel practices. Since many of the personnel issues are being, or have been, addressed by other VA and OIG elements, the bulk of our audit work has focused on issue pertaining to the economy, efficiency, and effectiveness of operations and only those personnel issues that had a direct impact on the audit.

DETAILS OF AUDIT

VHA Top Managers Need to Decide VA's Role in Emergency and Disaster Relief

EMSHG has been tasked with six specific missions related to national and local emergency and disaster preparedness and relief. These are listed in the preceding section. As these missions have been added over time, a relatively large, and at present dysfunctional, bureaucracy has been created to administer them. It is time to reassess whether EMSHG is the proper place organizationally for some of these missions.

In addition, based on an analysis of activities actually performed by EMSHG staff, EMSHG has assumed or been given tasks related to the six missions that would be better performed elsewhere in VA, elsewhere in the Federal Government, or not at all. The most obvious example of such activities are many that are performed by EMSHG Area Emergency Managers (AEMs) and their program assistants (PAs). These staff, who make up more than two-thirds of all EMSHG positions, perform some duties that either do not need to be done, that duplicate duties that should be performed by VA medical center or VISN staff, or that are completely unrelated to EMSHG's six authorized missions.

We found that one major component of the AEM and PA function includes duties related to their assigned FCCs within the NDMS. According to many AEMs,[7] these duties typically included such activities as:

- Networking among NDMS member hospitals and local and state government disaster agencies.
- Attending meetings of local and state government disaster agencies.
- Planning for area disasters.
- Planning and coordinating or assisting in the planning and coordinating of area disaster drills.
- Keeping up-to-date on NDMS member hospital capabilities.

However, these FCC and NDMS-related duties are not consistent with duties performed by similar staff in other Federal agencies having jurisdiction over other FCCs. According to the DoD official responsible for the FCC program in his agency, FCC staff only spend

[7] *Refer to footnote 1 on page 3 for clarification on AEM and PA duties.*

a small part of their time on FCC and NDMS duties. For Army staffed FCCs, this represents about one weekend a month for an Army reservist. For Navy and Air Force staffed FCCs, it is a minor collateral duty for active duty personnel. We concluded that once area private hospitals have been brought into the program, there is little else to do, except to occasionally update their capabilities inventory. While the other listed duties might have value, they are not required of an FCC official, VA or otherwise, and need not be performed for the purpose of maintaining an FCC site.

Many AEMs perform duties related to the development of medical center disaster plans, either for their own medical centers or for others within their VISNs, that go substantially beyond EMSHG's original tasking[8]. We found that some AEMs write their medical center's disaster plans even though that is a duty traditionally performed by medical center safety officers, especially at facilities that do not have AEMs.

In addition, most AEMs told us that they often take on tasks assigned by the Medical Center Directors where they are housed that do not relate to their EMSHG duties. A few estimated that these duties represented as much as 65 percent of their time. We also found that this situation occurred at least as frequently among PAs. In one case, we found that the Medical Center Director had used one full-time EMSHG PA for medical center purposes which had no relationship to any EMSHG mission or to anything having to do with emergencies or disasters.

The lack of consistency we found among AEMs as to their duties may relate to the dissolution of the old Medical Regions. Prior to 1995, AEMs were directly supervised by Regional Emergency Managers (REMs) assigned to the regions, and many of the activities in which AEMs were involved (disaster planning, disaster drills, etc.) were functions often coordinated through the Regions. Neither the REMs nor the coordinating function they represented exist any longer. Further, because EMSHG Headquarters does not have effective control of AEMs (see below), the 40 AEMs, with their PAs, tend to function as 40 independent units.

Lastly, we found that some AEMs occasionally were deployed to national disaster sites[9] to assist directly in disaster relief efforts. We question whether deployment to a disaster site is a necessary function of an AEM. Because deployment to disaster sites represents a separate general issue also involving EMSHG Headquarters staff, this issue is further discussed below.

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[8] *EMSHG was tasked with this function in 1992 by the then Chief Medical Director (now Under Secretary for Health). Unlike other authorized EMSHG missions, this one is internal to VA.*

[9] *Refer to footnote 2 on page 4 for clarification on AEM deployment to disaster sites.*

Legitimate and beneficial AEM functions (and by extension those of their PAs) should be transferred to the 22 VISNs. In our opinion, in many cases these functions can be assigned as collateral duties to existing VISN staff. However, we acknowledge that there may be local workload peculiarities that might require some VISNs to obtain additional staff. For example, the number of FCCs in each VISN varies from one to as many as six. In addition, some VISNs are in regions of the country that are more susceptible to large-scale natural disasters than others. If some VISNs require additional staff to perform legitimate AEM functions, these can be funded from savings derived from eliminating the present 69 FTEE AEM and PA positions. For reasons described in the next section, in our opinion, all VISN staff performing AEM functions should be directly funded from VISN allocations, and they should be exclusively controlled by VISN managers.

While the above discussions relate mainly to one particular group of EMSHG employee, we found that there were other mission issues that related to EMSHG as a whole. It is our general assessment that EMSHG's staffing, organization, and philosophical orientation are geared toward "managing" disaster relief efforts as opposed to simply facilitating the delivery of VA medical care resources when called upon. To support this assessment, we can offer two anecdotes in the following paragraph.

EMSHG officials stated that the purpose of deploying AEMs and headquarters staff to disaster sites was to provide "support" to VA medical care resources (physicians, nurses, technicians, supplies, and equipment) that may also have been deployed. While it was not exactly clear to us what this support normally consisted of, we were informed that it could include providing transportation and communication services to medical care staff. More importantly, it was never satisfactorily explained to us why FEMA and PHS staff should not be providing that kind of support at a disaster site. In fact, PHS officials complained to us that during one deployment EMSHG staff wanted to set up its own separate support unit that would have duplicated one set up by PHS staff. We were also informed that on another occasion EMSHG staff established a motor pool to provide transportation for VA relief workers despite the fact that PHS staff had already set up a motor pool for the same purpose.

In addition to those two examples, we also offer the following observations as evidence that EMSHG's current management is more focused on "managing" disaster relief efforts than on facilitating the delivery of VA medical care resources to a disaster situation:

- Much of the training and informational material developed and disseminated by EMSGH training staff relates more to disaster management techniques than it does to the treatment of disaster victims. This is to say it is oriented toward managers, not clinicians.

- EMSHG has invested large amounts of money in sophisticated communications equipment (satellite telephones and world-spanning short wave radios) to support EMSHG staff deployments.

- EMSHG Headquarters staffing of 24 FTEE is about twice the size of DoD's equivalent office.

These observations illustrate that EMSHG's basic reason for being revolves around disaster management, not the delivery of VA medical care in disaster relief. Further, this managing of relief efforts appears largely duplicative of FEMA and PHS missions.

VA does not need a large bureaucratic structure, as represented in EMSHG, simply to deliver medical care resources when asked to do so by FEMA or PHS officials. EMSHG's role could be limited primarily to:

- Identifying and cataloging available VA resources for different disaster scenarios.
- Activating such resources when FEMA, PHS, or DoD ask for them.
- Arranging primary transportation for such resources.

VHA management, with guidance from the VA Secretary's office, needs to determine whether "managing" disaster relief efforts is a proper role for VA or whether VA's role should be more focused on delivering medical care resources when called upon by other Federal agencies that are specifically tasked with disaster management.

DETAILS OF AUDIT

Organizational and Staffing Issues Need To Be Addressed

We identified a number of organizational and staffing issues involving EMSHG that need to be addressed. We found that EMSHG's officially approved organizational structure is significantly dissimilar to its actual structure. EMSHG does not have effective control over most of its staff and position descriptions for many of its staff are obsolete. We found that because it is doing work it does not need to do, EMSHG has more staff than it needs.

The AEM and PA positions are not a functioning part of the EMSHG organization. These staff are theoretically under the control of EMSHG management. They are reflected in the organizational hierarchy, are paid for from EMSHG funds, and are theoretically subject to EMSHG policies and directives. Yet, EMSHG does not have effective control over them. Rather, AEMs and PAs are directly controlled by Directors of the medical centers where they are assigned. This situation has created control problems.

Based on interviews with 10 AEMs and 8 PAs, we concluded that most of them believed they work for the local Medical Center Directors, not for EMSHG. In addition, document reviews showed that local Medical Center Directors (or their designees) were signing AEM position descriptions, performance appraisals, leave requests, time cards, travel approvals, and travel vouchers. We concluded that, for all intents and purposes, AEMs and PAs were medical center employees, not EMSHG employees, even though their salaries were funded from EMSHG's budget allocations.

As a consequence, we found that many AEMs were performing tasks assigned to them by the local Medical Center Directors that were not related to EMSHG missions or were only marginally related. The degree varied widely. The use of AEMs and PAs by local Directors for non-EMSHG mission duties was so pervasive that it called into question the need for dedicated, EMSHG-funded AEM and PA positions at most medical centers.

We found that EMSHG management had no effective control over AEM and PA position descriptions. While EMSHG management had prepared a model position description for AEMs, it was not in widespread use. In fact, we found that most AEMs had written their own position descriptions. These varied widely in content and, in our opinion, often reflected local priorities rather than EMSHG mission priorities.

Many AEMs traveled extensively. The amount of travel depended on location[10] and, apparently, on what the AEM believed his or her duties to be. We found that, despite funding all AEM and PA travel, EMSHG management had no effective control over their travel. EMSHG officials approved neither AEM travel requests nor their subsequent travel vouchers. Local Medical Center Directors, or their designees, did this. Because EMSHG funded all AEM travel, there was no financial incentive for local Directors to closely supervise AEM travel.

We identified several cases of questionable AEM travel claims. For example, we identified one case where a Director approved a travel claim for 7 days of TDY for an AEM to attend a 4 ½ day training conference. We identified several cases where TDY itineraries submitted by AEMs were not supported by accurate explanations. We also identified two AEMs who had been issued limited open travel authorizations by their local Directors despite this violating EMSHG policy.

We also found that EMSHG management had little effective control over AEM and PA training. While EMSHG policies do recommend certain types of training credentials for AEMs, EMSHG managers had no authority to require those training credentials. In addition, no one in EMSHG was able to show us what training their AEMs and PAs had actually received. What information we obtained about their training, we obtained directly from AEMs and from personnel files at medical centers.

General Schedule classifications of AEMs was inconsistent. Most AEMs were GS-13s, but among the 40 there were three GS-14s. These were former Regional Emergency Managers who were displaced when the Medical Regions were dissolved. Rather than being downgraded to GS-13s with "save pay," they had been "grandfathered" as GS-14s, even though they perform the same duties as GS-13 AEMs. In addition, during our audit, we were told that one of these GS-14s was, indeed, downgraded to a GS-13, but an attempt to downgrade another of the GS-14s was blocked by a VISN Director.

In our opinion, the status of AEMs and PAs within EMSHG's organizational structure needs to be reviewed by VHA top management. The present organizational alignment is not conducive to the effectiveness or efficiency of VA's emergency and contingency missions. EMSHG management was fully aware of the control problems that the *current* organization of AEMs and PAs had created. They expressed to us their belief that the solution lay in giving full "ownership" of AEMs and PAs to EMSHG.

In addition to organizational problems related to AEMs and PAs, we also identified organizational issues related to EMSHG headquarters itself. EMSGH headquarters'

[10] *Generally, there was less travel by AEMs on the densely-populated East Coast.*

organization has undergone evolutionary changes since the early 1990s. The dissolution of the Medical Regions necessitated some staffing adjustments. Supervisory realignments have been made. None of these are reflected in EMSHG's current approved organization chart. To address these changes and to attempt to solve the problem of AEM control, top management submitted a formal request for a new organizational structure to VHA Headquarters in 1997. This request has not been acted on.

We also found that EMSHG Headquarters was overstaffed. If EMSHG's basic mission can be reduced to facilitating the delivery of VA medical care resources to disaster sites, and AEM and PA duties can be transferred to VISN staff, EMSHG Headquarters staff could be reduced by as many as 15 positions. We base this assessment on experience in DoD, on reaction from PHS officials, and on our analysis of 18 of the 24 Headquarters positions. According to DoD officials, EMSHG's equivalent organization within DoD has only about 10 staff. In addition, PHS officials expressed surprise to us when informed of EMSHG's present staffing level. EMSHG Headquarters staff could be reduced from its present 24 FTEE to between 9 and 15 FTEE.

The following represents our analysis and conclusion regarding all of the positions reflected in EMSHG Headquarters' organization. It shows the title, series, and grade of each position as it existed at the time of our review, a synopsis of the duties actually performed in that position (regardless of the duties described in official position descriptions, which were not always the same), and our assessment about the need for the position in a redefined EMSHG.

Chief Consultant, ES-340-4

This position represents the "Director" of EMSHG and is intended to be filled by a physician. The incumbent during most of our audit was a non-physician, who filled the position on an acting basis only. This individual retired in late November 1998. Our assessment is that the position should be retained.

Deputy Director, ES-340-2

The incumbent was the former EMSHG Director. Presently, the position answers directly to the Acting Chief Consultant. The position was not utilized as a true Deputy. The incumbent supervised the Director of Response Support, the Director of Response Technical Support, and two AEMs, all of which we are recommending be eliminated. The incumbent also worked on an EMSHG newsletter and occasionally performed special assignments at the direction of the Acting Chief Consultant. This position should be eliminated.

Director, Response Support, GS-301-15

The position description was out of date. (Some documents referred to this position as "Director, Response Field Support" (emphasis added)). We were unable to identify any specific or routine duties performed by this position. This position should be eliminated.

Director, Response Technical Support, GS-301-14

The incumbent was one of the four former Regional Emergency Managers (REMs) who functioned under the now-defunct medical regions. While the other three REMs were converted to AEMs, this incumbent was not. He continued to function as a supervisor for those AEMs located in the former Region 1. AEMs in other parts of the country functioned without such a position. This position should be eliminated.

Director, National Programs, GS-301-15

The incumbent functioned as a true deputy director might. The incumbent had full line authority over virtually the entire EMSHG operation. (The only exceptions, on paper at least, were the "official" Deputy Director, the Director of Response Support, and the Director of Response Technical Support, all positions which we recommend eliminating.) Experience in a downsized EMSHG may be necessary before it can be determined if this position should remain. The need for this position should be assessed.

Director, Administration and Logistics, GS-341-13

The incumbent reported to the Director of National Programs and functioned as EMSHG's administrative officer, responsible for a variety of budget, fiscal, personnel, and other administrative matters. Assuming EMSHG is not downsized past a point of needing an administrative officer position, this position should probably be retained.

Logistics Specialist, GS-301-11

The incumbent was essentially a staff assistant to the Director of Administration and Logistics. In a downsized EMSHG, this position could be combined with the Budget Analyst position. This position should be eliminated.

Budget Analyst, GS-560-10

This position was responsible for budget and expenditure information in EMSHG. In a downsized EMSHG, this position should be combined with the Logistics Specialist position.

Director, Plans and Policy, GS-301-14

The incumbent reported to the Director of National Programs. The position was responsible for developing policies, plans, and procedures for the discharge of VA's obligations within the Federal emergency preparedness community. This position should be retained.

Planning Specialist, Natural and Technological Hazards, GS-345-13

This position reported to the Director, Plans and Policy. The position served as the planning and policy expert with regard to natural disaster and industrial accident situations. In a downsized EMSHG, it may be possible to combine this position with that of the Director, Plans and Policy. This position should be reassessed based on mission requirements.

Program Analyst for Plans and Policy, GS-343-11

The position reported directly to the Director, Plans and Policy. The position provided assistance in collecting, collating, and reporting data for various reports, including reports to Congress. The position should be reassessed based on mission requirements.

Program Manager, Plans, GS-301-13

The position reported directly to the Director, Plans and Policy. The position was vacant at the time of our review. According to the position description, an incumbent would develop plans and policies covering any and all operational matters and would provide technical guidance and assistance to EMSHG and other involved VHA officials and staff. Because we found no indication that these duties needed to be performed, and because there were no active plans to fill the position, we question whether it is needed either in EMSHG's current structure or in a downsized structure. This position should be eliminated.

Director, Operations, GS-301-14

The incumbent reported directly to the Director of National Programs. The incumbent was responsible for managing all aspects of "operations." He was responsible for communications, security, information resources, exercises, and physical support of deployed staff among other related duties. Within the present EMSHG structure, this was a vital position. However, if EMSHG's missions are adjusted to eliminate the deployment of EMSHG staff and the direct support of deployed VHA medical care staff, this position may not be necessary. This position should be reassessed based on mission requirements.

Program Manager, Telecommunications, GS-391-13

This position reported to the Director of Operations. The incumbent assisted in the acquisition of communications equipment forming VA's part of the National Communication System and was responsible for its maintenance. However, by the incumbent's estimate, only about 20 percent of her duties in this regard related directly to EMSHG activities. This position should be reassessed based on mission requirements.

Program Manager, Information Resources, GS-334-13

The incumbent reported to the Director of Operations. The incumbent essentially acted as the IRM officer for EMSHG, developing and maintaining EMSHG information systems and providing support for both hardware and software. The need for this position would increase based on the changes in EMSHG's primary focus that we recommend. This position should be retained.

Exercise Coordinator, GS-301-13

This position reported to the Director of Operations. The incumbent coordinated emergency response exercises, developed and maintained cost data related to such exercises, and assessed and reported on the effectiveness of exercises. Assuming that EMSHG is to continue acting as a resource for the VHA medical care elements that actually conduct emergency response exercises, this position or one like it would be beneficial. This position should be retained.

Operations Specialist, GS-301-9

This position reported directly to the Director of Operations. At the time of our review it was vacant, and there were no plans to fill it. According to the position description, an incumbent would be responsible for the readiness of EMSHG's Emergency Operations Center and would assist in activation of VA's Crisis Center if needed. Based on EMSHG acquiring a support mission, the position should be eliminated

Director, Transportation, GS-343-14

The position reported directly to the Director of National Programs. The incumbent arranged and coordinated military transportation for VA patients. Only incidentally did he do the same for EMSHG staff and for VHA resources deployed for emergency relief operations. The incumbent also maintained data on available VA beds for possible DoD use in the event they should be needed during a military crisis. By the incumbent's estimate, only about 50 percent of his time was

devoted directly to EMSHG functions. This position's duties need to be reassessed based on mission requirements.

Six Secretarial and Program Assistant Positions, GS-6 to GS-9

Supporting EMSHG Headquarters staff are four secretarial (GS-318) and two program assistant (GS-303) positions. These positions range from a grade 6 to a grade 9. We did not analyze these positions individually for their need either within EMSHG's current structure or in a downsized structure. However, if EMSHG's mission is changed and it is downsized, at least half of these positions will no longer be required.

If EMSHG's mission is changed and it is downsized as a result, at least nine positions could be eliminated from headquarters staffing.

- Deputy Director
- Director, Response Support
- Director, Response Technical Support
- Logistics Specialist or Budget Analyst
- Program Manager, Plans
- Operations Specialist
- Three Secretarial and/or Program Assistant Positions

We also concluded that another six positions need to be assessed by VHA management based on particular decisions made about the functioning of a redefined EMSHG. Two of these (marked with an *) need to be assessed to determine if they properly belong within EMSHG.

- Director, National Programs
- Planning Specialist, Natural and Technological Hazards
- Program Analyst for Plans and Policy
- Director, Operations
- Program Manager, Telecommunications*
- Director, Transportation*

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DETAILS OF AUDIT

EMSHG Management Does Not Have Effective Control Over Much of the Group's Operating Expenditures

EMSHG does not have effective control over operating expenditures related to its field staff, such as salaries, employee travel, equipment, and supplies. In Fiscal Year 1998, these expenditures exceeded $3.8 million. In addition, VA funds allocated by EMSHG to support NDMS activities, a minimum of $50,000 per year, were poorly controlled.

EMSHG does not have effective control over most of its operating budget. Because EMSHG monies are handled, and thus controlled, by several organizational elements in VHA, control of funds is cumbersome and difficult to manage centrally. The following description of the process illustrates this.

- Like other VHA funds, EMSHG budgeted funds initially reside in VHA accounts in VA Central Office. These funds are transferred[11] quarterly to 41 different VA medical centers across the country that support EMSHG operations and staff. The funds are controlled and ultimately disbursed by those 41 medical centers. There is no one, central control point within EMSHG for EMSHG's funds.

- Funds for EMSHG Headquarters operations are transferred to VAMC Martinsburg, WV, the medical center that supports EMSHG Headquarters. These funds reside in VAMC Martinsburg's fund control points and are expended by medical center fiscal staff on instructions from EMSHG officials.

- Funds for AEM and PA salaries, travel, and supplies are transferred to the 40 VA medical centers that support them. Those funds reside in medical center fund control points and are expended from those control points by medical center staff at the 40 facilities as needed or as requested.

- Funds for EMSHG's Training and Development staff in Indianapolis, IN are transferred to VAMC Indianapolis. These funds reside in medical center fund control points and are expended from those control points by medical center fiscal staff at the request of EMSHG staff. (VAMC Indianapolis also serves an AEM position.)

[11] *Technically, it is the disbursing authority that is transferred (TDA — temporary disbursing authority), not the funds themselves.*

- Funds for one out-based EMSHG headquarters staff person are transferred to VAMC Lyons, NJ, the employee's official duty station, and are similarly handled from that medical center's fund control points. (VAMC Lyons also serves an AEM position.)

- Funds for another out-based EMSHG staff person, located at Scott Air Force Base, are handled by VAMC Martinsburg fiscal staff.

- From time to time, funds may be transferred to the various medical centers at the direction of EMSHG officials as needed to support EMSHG staff.

Only one person at EMSHG Headquarters, a budget analyst, was tasked specifically with keeping track of EMSHG funds. Given the totally decentralized nature of EMSHG allocations and expenditures, we found it not surprising that control problems occurred. We found that some medical centers that supported EMSHG operations inappropriately retained unspent EMSHG funds, including funds for vacant AEM and PA positions. We also found that EMSHG Headquarters staff did not have adequate control over AEM travel. Lastly, we identified several problem conditions related to funds provided by VA, through EMSHG, to support NDMS activities.

Because EMSHG management did not adequately monitor expenditures made by supporting medical centers for EMSHG operations, approximately $414,000 in unspent and unneeded EMSHG funds were simply absorbed by those medical centers for their own purposes. The practice of medical centers keeping funds that were not needed for EMSHG operations deprived both EMSHG and VHA of the opportunity to reallocate those funds based on national priorities. We documented the following examples of this practice:

- Approximately $221,000 in net[12] unspent, end-of-year funds for support of EMSHG Headquarters staff were absorbed by VAMC Martinsburg. This also included salary, travel, supply, and other miscellaneous categories of funds and covered the period from Fiscal Year 1992 through Fiscal Year 1997.

- Approximately $162,000 in unspent EMSHG funds was absorbed by four medical centers for AEM and PA positions that were either vacant or were misidentified as to the applicable FTEE. Another $5,500 in VHA funds for overhead for these vacant or misidentified positions was kept by these medical centers. These

[12] *Prior to Fiscal Year 1996, EMSHG did not have its own separate budget. Its budget was subsumed within the Martinsburg medical center budget. In Fiscal Year 1993, the medical center actually transferred about $66,000 from its own fund control points to EMSHG fund control points to cover EMSHG operations. In all other years from Fiscal Years 1992 through 1997 about $287,000 flowed the other way.*

examples occurred in Fiscal Years 1997 and 1998. The funds were for salaries and for administrative overhead.

- Approximately $25,400 in unspent Fiscal Year 1997 funds for support of field AEMs and PAs was absorbed by 31 medical centers. This included salary and travel funds.

In addition," we found that EMSHG Headquarters staff did not have adequate control over AEM travel. In Fiscal Year 1998, this totaled over $214,000. Directors at the medical centers where AEMs were assigned generally approved AEM travel requests and subsequent travel claims. This occurred despite the fact that EMSHG provided the travel funds. We identified several cases of questionable travel by AEMs that might have been prevented if the funding and the approving authority had been from the same source.

Lastly, EMSHG officials did not have effective control over funds provided to support NDMS operations, which amounted to at least $50,000 each year. In cooperation with PHS, FEMA, and DoD, VA helps fund operations of the National Disaster Medical System. The largest single expenditure of NDMS each year is its annual "NDMS Training Conference." For several years, VA's EMSHG staff have played the lead role in planning and executing this conference. Because NDMS is only a "virtual" organization[13], there is no central control point to account for funds from the four agencies for conference expenditures.

We attempted to audit the expenditure of VA funds for support of the 1997 NDMS conference. That conference was held in April 1997 in Tampa, FL. Approximately 500 people attended the conference from VA, PHS, FEMA, DoD, numerous state and local governments, and various private sector organizations involved in disaster planning and recovery. We were unable to account for all funds ostensibly expended by VA in support of that conference. Neither were we able to confirm any contributions made by any of the other three supporting agencies.

EMSHG staff responsible for overseeing the conference were unable to perform a successful accounting of all conference-related expenditures. We attempted to reconstruct conference-related contributions, attendance fees, and expenses in order to account for all conference funds provided or controlled by VA. Conference-related monies can be separated into two general categories:

[13] *The language that is often used to refer to NDMS can be misleading. NDMS is a "system" rather than an agency of the Federal government. It has no staff, no space, and no appropriated funds of its own. Its functioning is completely supported by funded Federal agencies.*

- "Pre-conference expenses" paid for from EMSHG budgeted and appropriated funds. The Regional Medical Education Center (RMEC) in Birmingham, AL handled these funds. The expenses paid for consisted mostly of VA employee travel related to finding and arranging for a suitable conference site. Other expenses included the procurement of nametags, paper binders, and other such small cost items.

- "Direct conference-related expenses" were paid for from participant fees (not appropriated monies). A non-profit private contractor, hired by the RMEC, collected participant fees and paid conference-related expenses, such as speaker fees, conference space, audio-visual services, and break time snack food and drinks.

We were unable to account for all funds. According to EMSHG and VA Central Office fiscal records, $26,686 was transferred, in two installments, to the Birmingham RMEC in Fiscal Year 1997 for NDMS conference-related purposes. Reviews of all available RMEC and VAMC Birmingham fiscal records could only account for about $13,785 actually spent by RMEC officials on conference-related expenses. We found that another $4,200 was improperly spent by RMEC officials on expenses not related to EMSHG's participation in the conference.[14] Available records suggest that the remaining $8,700 was simply absorbed by VAMC Birmingham at fiscal year end, similar to what other medical centers had done with unspent EMSHG funds.

We were also unable to determine the disposition of EMSHG funds that were reportedly left over in RMEC accounts from the prior year's (Fiscal Year 1996) conference. According to secondary source documents provided by EMSHG officials, there was an unspent balance of $33,590 in RMEC accounts at the conclusion of the 1996 NDMS conference. However, our reviews of RMEC and VAMC Birmingham primary source fiscal records showed that no such funds were carried over for the 1997 conference. Further inquiry revealed that:

- Either, as medical center fiscal staff speculated and as they insisted sometimes happens, some of the 1996 NDMS money arrived at the medical center without adequate explanation of its purpose. (If RMEC officials failed to clarify its purpose, the money would have been deposited into the "miscellaneous" RMEC fund control point, thus co-mingling it with other RMEC monies and making it difficult to identify.)

[14] *It appears that this was for expenses related to Birmingham VA Medical Center participation in the conference, and thus should not have come from EMSHG funds.*

- Or, medical center staff "banked" the money. (Medical center fiscal staff described a practice they called "banking." This is a practice that "sweeps up" all monies from the several RMEC fund control points before the close of a fiscal year. These funds are redeposited into medical center fund control points and spent for medical center purposes. After the beginning of the new fiscal year, the medical center repays to one RMEC account all funds that it took in the previous fiscal year. However, at this point any EMSHG money would no longer be identifiable from other monies that may have been included in the "sweep.")

- Or, medical center fiscal staff simply absorbed the money at year end as other medical centers had done with other unspent EMSHG funds.

No conclusive disposition of the $33,590 could be determined. However, evidence suggested the money was probably "banked." Regardless of that, this situation clearly demonstrates a need for EMSHG officials to better control their money.

We also identified a questionable transaction involving monies related directly to the conference itself. These monies were from attendance fees paid by persons attending the conference and were not, technically at that point, appropriated funds.[15] RMEC staff hired a non-profit organization as a contractor to collect, control and disburse those funds.

Our review of accounting records provided to us by the contractor identified one unusual transaction. According to contractor records, the contractor paid $3,000 from conference receipts to the hotel for one line item called "gratuities." This $3,000 was then given in cash to an EMSHG employee who was to have distributed it to various vendor staff, mostly hotel staff, as tips. The only documentation available showing to whom the tips were finally disbursed were handwritten notes prepared by the EMSHG employee to whom the cash was first given. These notes generally only provided the first names of the staff who received the tips.

It is important for us to make clear that we have no evidence that anyone or any organization improperly profited from these conditions. We did conclude, however, that under the conditions we observed, undetected fraud could have been committed and that it was imprudent of EMSHG officials not to insist on a better accounting for EMSHG and conference monies. At a minimum, this lack of control allowed $46,400 ($8,700 + $4,200 + $33,500) in EMSHG monies to be spent for purposes for which the funds were not intended.

[15] *Of course, in the case of Federal participants, some, perhaps most, of these fees were paid by the Federal agencies sponsoring the attendees. Those payments undoubtedly would have come from appropriated funds.*

In future years, if EMSHG continues to sponsor or participate financially in NDMS conferences, EMSHG officials should insist on a thorough accounting of all funds, appropriated or otherwise, that are associated with the conference. This applies both to funds provided to a VA entity, such as a RMEC, and to funds controlled by non-VA entities, whether the funds derive from VA appropriations or from other sources associated with the conference.

Because other Federal agencies will likely be involved in NDMS conference planning, execution, and funding, it may be necessary for EMSHG to negotiate with those agencies regarding acceptable fiscal controls. It is incumbent on EMSHG officials to assure themselves, through appropriate accounting mechanisms, that EMSHG funds are used as they are intended to be used, in support of EMSHG's mission.

FULL TEXT OF UNDER SECRETARY FOR HEALTH COMMENTS

Department of Veterans Affairs

Memorandum

Date: APR 2, 1999

From: Under Secretary for Health (10/105E)

Subj: OIG Draft Report, *Audit of Emergency Management Strategic Healthcare Group (EMSHG) Management and Operations,* Project No. 7R4-465 (EDMS #43519)

To: Assistant Inspector General for Auditing (52)

1. The appropriate program offices have reviewed the draft report. Your report appears to provide a thorough and candid evaluation of this important office, and I believe it will be very useful to us as we restructure this Strategic Healthcare Group. We generally concur with the report's recommendations and estimate of better use of funds. We are, however, deferring our concurrence on recommendation c. until a permanent Chief Consultant is appointed and has an opportunity to assess the situation.

2. There are a number of circumstances that will affect the planning for and timing of the implementation of the recommendations. First, a new Chief Consultant, EMSHG, will be in place in late April 1999. Understandably, the new Chief Consultant will require some time to assess the situation and to best determine how to proceed with implementing needed change. We believe your report will greatly assist the new Chief Consultant in this effort. Second, although we agree that staffing resources are not currently being maximized, as part of the process of determining VA's future role in disaster management, we must consider potential expanded roles for VA, such as in the area of weapons of mass destruction, which you mention in your management advisory. Resources that might otherwise be considered excess (including positions in EMSHG headquarters, area manager and training staff) could be redirected to enhance VA's ability to contribute to the federal role in this area.

3. Attached is an action plan for implementing the recommendations. If you have any questions, please contact Paul C. Gibert, Jr., Director, Management Review and Administration Service (105E), Office of Policy and Planning, at 202.273.8355.

4. Thank you for the opportunity to review the draft report.

Original signed by
Kenneth W. Kizer, M.D., M.P.H.

Attachment

VA FORM MAR 1989 **2105**

FULL TEXT OF UNDER SECRETARY FOR HEALTH COMMENTS (Continued)

Action Plan in Response to OIG/GAO/MI Audits/Program Evaluations/Reviews

Name of Report: *Audit of Emergency Management Strategic Healthcare Group Management and Operations*
Project No.: 7R4-465
Date of Report: Undated draft report

Recommendations/ Actions	Status	Completion Date

The Under Secretary for Health should:

a. Determine what VA's role in disaster management should be.

Concur

As part of the restructuring of EMSHG, the new Chief Consultant will assume a lead role in advising the Under Secretary for Health about a redefined role for VHA in disaster management. All applicable public laws, executive orders, Presidential Decision Directives and VA policies will be considered in this task. Affected external agencies will also be consulted. Once VHA/DVA's roles are determined, VHA/DVA directives and other policies will be amended as necessary.

In process 9/30/99

b. Adjust EMSHG Headquarters staffing levels accordingly.

Concur

Once the VHA/DVA's roles are defined, EMSHG Headquarters roles and responsibilities will be addressed and staffing adjusted accordingly.

In process 9/30/99

c. Eliminate AEM and PA positions and transfer their essential Federal Coordinating Center duties to the 22 Veterans Integrated Service Networks.

Defer concurrence

The report identifies many deficiencies associated with the function and management of these positions; however, we believe further study *vis a vis* the restructuring of EMSHG

FULL TEXT OF UNDER SECRETARY FOR HEALTH COMMENTS (Continued)

2. Action Plan in Response to OIG/GAO/MI Audits/Program Evaluations/Reviews

Name of Report: *Audit of Emergency Management Strategic Healthcare Group Management and Operations*
Project No.: 7R4-465
Date of Report: Undated draft report

Recommendations/ Actions	Status	Completion Date

Recommendation c. Continued:

is necessary to ensure that staffing resources are appropriate and to ensure that a viable mechanism is in place for the networks or medical centers to meet the requirements of the program with appropriate expertise. These needs will be determined as part of the Chief Consultant's restructuring effort.

In process 9/30/99

d. Eliminate the Deputy Director and Director, Response Field Support Unit positions in EMSHG Headquarters.

Concur

To be accomplished as part of the EMSHG restructuring by the Chief Consultant.

In process 9/30/99

e. Establish accounting mechanisms to track and account for EMSHG expenditures, and to identify and permit reallocation of unneeded funds.

Concur

Appropriate mechanisms will be established, and the Chief Consultant will be delegated these authorities.

In process 10/1/99

f. Determine whether VA should continue to provide financial support to the annual NDMS conference.

FULL TEXT OF UNDER SECRETARY FOR HEALTH COMMENTS (Continued)

3. Action Plan in Response to OIG/GAO/MI Audits/Program Evaluations/Reviews

Name of Report: *Audit of Emergency Management Strategic Healthcare Group Management and Operations*
Project No.: 7R4-465
Date of Report: Undated draft report

Recommendations/ Actions	Status	Completion Date

Recommendation f. Continued:

Concur

VHA determined in FY 1997 that financial support for the NDMS conference would end with the May 1997 meeting. In FY 1998 and FY 1999 no funds were budgeted or transferred by EMSHG to the Public Health Service, or any other agency, for financial support of this conference. The decisions and their implementation to conduct the annual NDMS conference on a self-sustaining basis and to employ an independent entity to manage the finances were proposed by EMSHG management and made by NDMS officials prior to the OIG audit.

Completed 10/1/97

g. Evaluate the need for the EMSHG training and development unit in Indianapolis.

Concur

An evaluation of the need for this unit will be completed as part of the restructuring effort.

In process 9/30/99

MONETARY BENEFITS

IN ACCORDANCE WITH IG ACT AMENDMENTS

Report Title: Audit of Veterans Health Administration
Emergency Medical Strategic Healthcare Group

Project No: 7R4-465

		OIG ESTIMATE		AUDITEE ESTIMATE	
Rec. No.	**Recommendation**	**Questioned Costs**	**Recommended Better Use of Funds**	**Questioned Costs**	**Recommended Better Use of Funds**
1b.	Approximate savings from a reduction in EMSHG Headquarters staffing from 24 FTEE to 17 FTEE.		$ 335,000		$ 335,000
1c.	Approximate savings from eliminating AEM and PA positions.		4,000,000		4,000,000*****
1d.	Approximate savings from eliminating two additional Headquarters positions.		190,000		190,000
1f.	Annually recurring VA funds used to support NDMS that could be better controlled by adequate accounting.		50,000		50,000
	TOTAL		$4,575,000		$4,575,000

*****The Under Secretary for Health deferred concurrence with Recommendation 1c. until a permanent Chief Consultant was appointed and could assess the situation.

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