Office of Inspector General

Semiannual Report to Congress

April 1, 2000 – September 30, 2000

FOREWORD

I am pleased to submit the semiannual report on the activities of the Department of Veterans Affairs (VA), Office of Inspector General (OIG) for the period ended September 30, 2000. The OIG is dedicated to help ensure that veterans and their families receive the care, support, and recognition they have earned through service to their country. This report is issued in accordance with the provisions of the Inspector General Act of 1978, as amended.

Most significant in the protection of veterans was the prosecution of Dr. Michael Swango. After a 7-year investigation by our Office of Investigations, with assistance by our Office of Healthcare Inspections, Swango pleaded guilty in Federal court to the murder of three veterans under his care at a VA medical center (VAMC). He also admitted to the murder of a 19-year-old patient at a university hospital in 1984. Swango was sentenced to three consecutive life terms in prison with no possibility of parole.

Our criminal investigations continue to target cases of public corruption and major thefts, instances where incapacitated veterans fall victim to unscrupulous individuals, and fraud involving programs for the delivery of benefits to veterans. We place a priority on safety and security at VA medical centers. Allegations of fraud demand an immediate response. The OIG will take decisive action against those who prey on veterans and will hold accountable those VA employees who disregard their public trust responsibilities. During the period, OIG criminal and administrative investigations yielded 174 arrests, 156 indictments, 122 criminal convictions, and 195 administrative actions, foremost of which were cases involving fraud and employee misconduct.

Our oversight of VA, the second largest Department in the Federal Government, covers medical care, benefits administration, procurement, financial management, facilities management, and information technology. The audits and evaluations focused on determining how programs can work better, while improving service to veterans and their families. OIG audits, investigations, and other reviews identified over $54 million in monetary benefits. For example, an audit presented opportunities to reduce pharmaceutical inventories by over 59 percent or $31 million. Monetary benefits of this type can be redirected to programs that can improve or increase services to veterans. In addition, a noteworthy accomplishment was our evaluation of security controls for VA automated data processing systems that identified a number of significant control weaknesses and provided several recommendations for enhancing security of the systems tested.

Since VA operates the largest health care system in the United States, the focus of OIG Healthcare Inspections is on quality of care issues. This includes a proactive review of the Veterans Health Administration's (VHA's) patient safety program. Healthcare inspectors also oversee VHA's Office of Medical Inspector activities and review the adequacy of VA's responses to allegations of inadequate health care management and patient care.

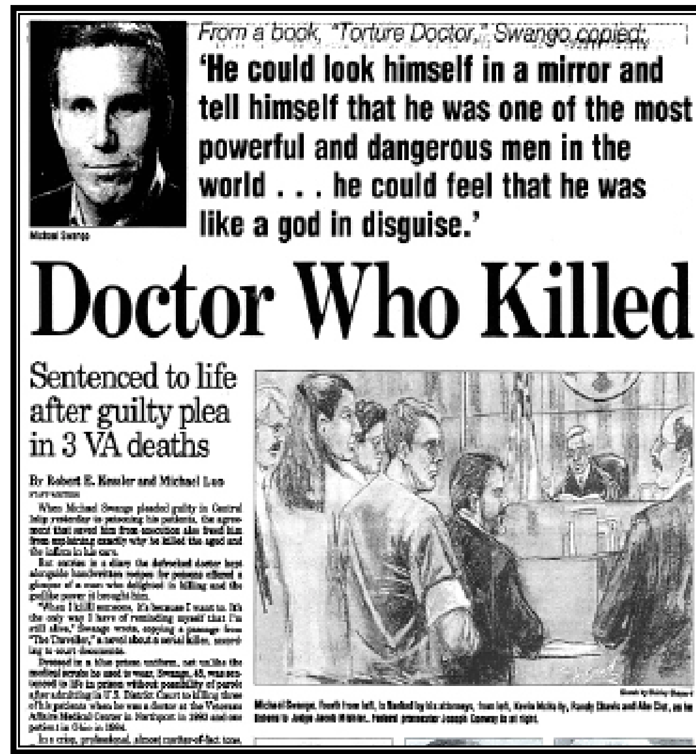
The OIG's ongoing Combined Assessment Program (CAP) evaluates the quality, efficiency, and effectiveness of VA facilities. Through this program, auditors, investigators, and healthcare inspectors collaborate to assess key operations and programs at VAMCs on a cyclical basis. The 14 CAP reviews completed during this 6-month reporting period highlighted numerous opportunities for improvement in quality of care, management controls, and fraud prevention. Through increased or restructured resources, I am committed to extending this program to enable more frequent oversight of VA activities.

I look forward to continued partnership with the Secretary and the Congress in improving service to our Nation's veterans.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

INSPECTOR
GENERAL

VA OIG
CASE OF 2000



From a book, "Torture Doctor," Swango copied:

'He could look himself in a mirror and tell himself that he was one of the most powerful and dangerous men in the world . . . he could feel that he was like a god in disguise.'

Doctor Who Killed

Sentenced to life after guilty plea in 3 VA deaths

By Robert E. Kessler and Michael Luo

For 7 years, VA OIG agents and healthcare inspectors, along with the Office of the U.S. Attorney and the FBI worked to put Dr. Michael J. Swango permanently behind bars. On September 7, 2000, Swango pleaded guilty to the murder of three veterans in his care at VA Medical Center (VAMC) Northport, NY. He was sentenced to three consecutive life terms without the possibility of parole for the VAMC murders.

The Ohio Murder and Assault

Michael Swango graduated from the Southern Illinois University Medical School in 1983 and began the internship program at Ohio State University Hospital upon his graduation. As spelled out in the indictment, while working as an intern at Ohio State University Hospital in January 1984, Dr. Swango murdered Cynthia McGee by injecting her with a lethal dose of potassium. In February 1984, he assaulted his patient, Rena Cooper, by injecting her with a poisonous substance. She survived the attack. After that assault, Ohio State University Hospital removed Dr.

Swango from the residency program, and in 1985 Ohio authorities commenced a murder investigation into his activities. Although that investigation did not result in the filing of charges against Swango, he did learn of the investigation and concealed the fact that he was investigated for murdering patients from the other hospitals that subsequently hired him.

Adams County Ambulance Service

In 1985, Swango began employment at the Adams County, Illinois, Ambulance Service as an emergency medical technician. According to the indictment, he poisoned several of his co-workers there with arsenic. They later recovered and he was tried and convicted of aggravated battery. He was sentenced to a 5-year term of imprisonment.

Northport Murders and Assault

Several years after his release from an Illinois prison, Swango sought admission to several medical residency programs. In 1992, he was hired by the University of South Dakota and assigned to work as a resident at the VAMC Sioux Falls, South Dakota, after he falsified facts about his prior criminal conviction. Swango was discharged from the program after hospital administrators became aware of the facts surrounding his conviction and his activities at Ohio State University Hospital.

In 1993, Swango applied for and obtained a position as a medical resident at the State University of Stony Brook Medical School, which ran a residency program at VAMC Northport. During the application process, he misrepresented that his criminal conviction in Illinois stemmed from a barroom brawl; a false statement that ultimately led to his conviction and incarceration on Federal charges.

Thereafter, Swango murdered George Siano, Aldo Serini and Thomas Sammarco, while all three were patients at VAMC Northport. Swango killed all three patients by administering injections of toxic substances. In addition, Swango also injected a poison into another patient at the hospital, Barron Harris. Mr. Harris survived the incident.

In October 1993 Swango was discharged from his residency at VAMC Northport, and was later charged with making a false statement to Federal officials and improper use of controlled substances in connection with his employment there. Before those charges were filed

VA OIG, FBI and Federal Prosecutors speak to the press outside the U.S. District Court House in Central Islip, NY following the conviction of Dr. Michael Swango for the murder of three veteran patients at the Northport VA Medical Center.

however, he fled the United States and was hired as a physician at the Zimbabwe Association of Church Hospitals.

The Zimbabwe Assaults

On May 14, 1995 and July 7, 1995, respectively, Swango administered injections of toxic substances into his patients Kenias Mueaza and Virginia Sibanda, both of whom were under his care at Mnene Hospital in Zimbabwe, Africa. Both survived Swango's attacks. Swango was suspended from practice at Mnene Hospital in July 1995.

Saudi Arabia

In 1997, as a result of false statements, Swango obtained employment as a physician through KAMA Enterprises, Inc., an employment agency in Portland, Oregon, and was assigned to work as a physician at the Royal Hospital in Dharan, Saudi Arabia. In June 1997, Swango was arrested in a Chicago airport on his way from Africa to Saudi Arabia, to begin his employment there. He was arrested for the false statement and controlled substance charges that had been filed in the Eastern Judicial District of New York.

Making the Case

While Swango was imprisoned on this charge, VA OIG investigators and healthcare inspectors, FBI agents, and U.S. Attorneys had limited time to find the evidence to make the case for the three deaths which happened in a federal facility. Extensive review of records, laboratory studies, and interviewing witnesses in the United States and Africa took thousands of hours. In that effort, the team received the full cooperation and support from the management and staff at VA Medical Center Northport, NY.

The Guilty Plea and Sentence

Faced with the possibility of a death sentence, Swango pleaded guilty to the murder of the three veterans in New York and was sentenced to three consecutive life terms without parole.

VA IG Richard Griffin and U.S. Attorney Loretta Lynch

"Through a web of lies and deception, Michael Swango inveigled his way into the confidence of hospital administrators across the country and the world. Once in their trust and employ, he utilized his skills to search for victims and take their lives. This case is the result of the hard work and diligent efforts of not just this office but of the Federal Bureau of Investigation and the Department of Veterans Affairs Office of Inspector General, who were determined that Swango be held accountable for his actions and not be allowed to victimize others. I thank both of those agencies for their dedication and determination in investigating this matter, across the years and the globe. We extend our deepest sympathies to the victims and their families."

Loretta E. Lynch
United States Attorney

TABLE OF CONTENTS

	Page
HIGHLIGHTS OF OIG OPERATIONS	**i**
VA AND OIG MISSION, ORGANIZATION, AND RESOURCES	**1**
COMBINED ASSESSMENT PROGRAM	**7**
OFFICE OF INVESTIGATIONS	
Mission Statement	**15**
Resources	**15**
Criminal Investigations	**15**
Veterans Health Administration	**16**
Veterans Benefits Administration	**27**
Board of Veterans' Appeals	**39**
Office of Human Resources and Administration	**39**
National Cemetery Administration	**40**
OIG Forensic Documents Laboratory	**40**
Administrative Investigations	**41**
Veterans Health Administration	**42**
Veterans Benefits Administration	**43**
OFFICE OF AUDIT	
Mission Statement	**45**
Resources	**45**
Overall Performance	**45**
Veterans Health Administration	**46**
Veterans Benefits Administration	**49**
Office of Management	**50**
Multiple Office Action	**52**
Implementation of GPRA in VA	**53**
OFFICE OF HEALTHCARE INSPECTIONS	
Mission Statement	**55**
Resources	**55**
Overall Performance	**55**
Veterans Health Administration	**55**
OFFICE OF MANAGEMENT AND ADMINISTRATION	
Mission Statement	**61**
Resources	**61**
Hotline Division	**62**
Veterans Health Administration	**63**
Veterans Benefits Administration	**68**
National Cemetery Administration	**69**
Board of Veterans' Appeals	**69**
Operational Support Division	**70**
Status of OIG Reports Unimplemented for Over 3 Years	**71**
Veterans Health Administration	**72**
Veterans Benefits Administration	**73**
Information Technology and Data Analysis Division	**74**
Resources Management Division	**78**
OTHER SIGNIFICANT OIG ACTIVITIES	
President's Council on Integrity and Efficiency	**79**
OIG Management Presentations	**79**
Awards	**80**
OIG Congressional Testimony	**81**
Obtaining Required Information or Assistance	**81**

Page

APPENDIX A -	REVIEWS BY OIG STAFF	83
APPENDIX B -	CONTRACT REVIEWS BY OTHER AGENCIES	91
APPENDIX C -	CONTRACT REVIEW REPORTS FOR WHICH A CONTRACTING OFFICER DECISION HAD NOT BEEN MADE FOR OVER 6 MONTHS	93
APPENDIX D -	FOLLOW UP/RESOLUTION OF OIG REPORTS	97
APPENDIX E -	REPORTING REQUIREMENTS OF THE INSPECTOR GENERAL	101
APPENDIX F -	OIG OPERATIONS PHONE LIST	103
APPENDIX G -	GLOSSARY	105

HIGHLIGHTS OF OIG OPERATIONS

This semiannual report highlights the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for the 6-month period ended September 30, 2000. The following statistical data highlights OIG activities and accomplishments during the reporting period.

	Current 6 Months 4/1/00 – 9/30/00	FY 2000 10/1/99 – 9/30/00
DOLLAR IMPACT	Dollars in Millions	
Funds Put to Better Use	$41.7	$302.2
Dollar Recoveries	$6.0	$11.4
Fines, Penalties, Restitutions, and Civil Judgments	$7.2	$13.8
RETURN ON INVESTMENT		
Dollar Impact ($54.9) / Cost of OIG Operations ($24.6)	2 : 1	
Dollar Impact ($327.4) / Cost of OIG Operations ($45.4)		7 : 1
OTHER IMPACT		
Arrests	174	338
Indictments	156	280
Convictions	122	247
Administrative Sanctions	195	496
ACTIVITIES		
Reports Issued		
Combined Assessment Program	14	18
Audits	19	35
Contract Reviews	24	40
Healthcare Inspections	9	15
Administrative Investigations	8	16
Investigative Cases		
Opened	478	882
Closed	316	545
Hotline Activities		
Contacts	8,319	15,771
Cases Opened	547	985
Cases Closed	461	717

OFFICE OF INVESTIGATIONS

Overall Focus

During the semiannual period, the Office of Investigations focused its resources on investigations that have the highest impact on the programs and operations of the Department. Criminal investigative

priority continues to target cases of public corruption, procurement fraud, healthcare fraud, instances where incapacitated veterans fall victim to unscrupulous fiduciaries, and fraud involving programs for the delivery of benefits to veterans. Emphasis has also been placed on safety and security at VA medical centers (VAMCs) and a strong working relationship has been developed with the VA Office of Security and Law Enforcement along with VA police throughout the nation. Immediate response to criminal allegations is absolutely essential and demonstrates that the OIG will take decisive action against those who prey on veterans and will hold accountable those VA employees who disregard their public trust responsibilities.

Results

During the period, the Criminal Investigations Division concluded 316 investigations resulting in 278 judicial actions and over $13.9 million recovered or saved. Investigative activities resulted in the arrests of 174 individuals who had committed crimes involving VA programs and operations or on VA facilities. In addition, the division realized monetary benefits of approximately $9 returned or saved by the Government for each dollar spent. The Administrative Investigations Division concentrated its resources on investigating allegations against high-ranking VA officials concerning misconduct and other matters of interest to the Congress and the Department. The division completed 22 administrative investigations this period and issued 8 reports. These investigations resulted in administrative action taken against 11 high-ranking officials and other employees, and 7 corrective actions taken by management to improve VA operations and activities.

Veterans Health Administration (VHA) and Veterans Benefit Administration (VBA)

The Office of Investigations, working hand-in-hand with VA police, assisted in over 40 arrests of individuals who committed crimes at VAMCs. Over 300 investigations were initiated in the benefits fraud area of individuals that were fraudulently diverting VA funds. This period brought the conclusion to many investigative cases which led to significant results. A former VA employee was sentenced to 25 years in prison after admitting to stealing drugs and video equipment from a VA hospital. He used the equipment to videotape himself in sexual acts with underage children whom he had knocked out with stolen drugs. In another high profile investigation, a pastor of a church pleaded guilty to stealing over $118,000 in VA funds. The individual diverted the funds, earmarked for a homeless veteran project, to a real estate business that he operated. Most significant was the completion of a 7-year investigation resulting in guilty pleas by Dr. Michael Swango to three counts of murder and two counts of fraud.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for $40.6 Million

Audits and evaluations were conducted which focused on determining how programs can work better, while improving service to veterans. During this reporting period, 33 performance, financial, and Combined Assessment Program (CAP) audits, evaluations, and reviews, as well as 24 contract reviews identified opportunities to save or make better use of $40.6 million. The Office of Audit returned $3 for every dollar spent on performance and financial audits. Contract reviews returned $8 in monetary benefits for every dollar spent.

Veterans Health Administration

The following are examples of major health care related audits. Our audit of VAMC pharmaceutical inventories found that VA could further reduce inventories by effectively using modern techniques and automated inventory management. We reported that pharmaceutical inventories could be reduced by $31 million. Also an audit of VA's Workers' Compensation Program (WCP) found that a Veterans Integrated Service Network (VISN) had initiated action to help improve WCP management. However, additional efforts were needed to strengthen case management to assure the appropriateness of some claims which would reduce annual costs by $3 million with an estimated lifetime benefit reduction of $38 million.

Veterans Benefits Administration

At the request of the Under Secretary for Benefits, and with other OIG components, we audited internal controls for the adjudication and payment of Compensation and Pension (C&P) benefits at VA Regional Office (VARO) St. Petersburg, FL. The purpose of the audit was to determine whether internal control vulnerabilities existed that may facilitate fraud or claims examination error, and to probe for potential on-going fraud that may have escaped detection by VA and VARO controls. We confirmed that 16 of 18 categories of vulnerability reported in our last semiannual report were present at VARO St. Petersburg. Also, 139 cases of potential fraud were referred for investigation or administrative review.

Office of Management

As part of the Consolidated Financial Statements (CFS) audit, we issued eight management letters addressing financial reporting and control issues. The management letters provided Department managers additional observations and advice that will enable the Department to improve day-to-day accounting operations and controls, and help sustain VA's efforts in achieving an unqualified opinion on its CFS. The management letters contained observations concerning: (i) VBA's benefit program; (ii) property, plant, and equipment; (iii) payroll; (iv) medical facility receivables; and (v) automated data processing (ADP) security.

Contract Review and Evaluation

During the period, we completed 24 contract reviews – 12 postaward and 12 preaward reviews. Contract reviews identified monetary benefits of $7.8 million associated with postaward and preaward reviews, resulting from contractor actual or potential overcharges to VA.

Multiple Office Action

As part of our audit of VA's FY 1999 CFS, the OIG, together with a contracted independent public accounting firm, conducted penetration tests of selected VA systems. The review identified significant control weaknesses that allowed unauthorized access to sensitive VA data. We made several recommendations as well as additional specific findings and measures for enhancing security of the systems tested. The results of this audit led to a hearing by the House Committee on Veterans' Affairs and establishment of a Department wide correction plan to eliminate VA's ADP vulnerability to penetration.

OFFICE OF HEALTHCARE INSPECTIONS

During this reporting period, CAP reviews occupied approximately 75 percent of Office of Healthcare Inspections (OHI) resources. In addition, OHI focused on more active oversight of the 82 Hotline cases sent to VHA program offices and the VHA Medical Inspector. In 11 of these cases, OHI was not satisfied with the VHA response and recommended that it receive further study. The reporting period also saw the culmination of the Swango case. Throughout the 7 years of this investigation, which is detailed elsewhere in this report, OHI staff worked diligently as clinical team member/consultants to the Office of Investigations in order to locate and develop evidence sufficient for conviction of Dr. Swango.

Program Review

A major program review of this period was conducted in response to inquiries received from veterans service organizations on whether VHA clinicians were appropriately discharging long-term VA nursing home care unit (NHCU) patients to community-based facilities. OHI visited 6 of the 13 sites found to have an average length-of-stay over the national average, concentrating on patients who had been in a VA NHCU for more than 730 days. We concluded that effective discharge planning was accomplished at the sites visited using interdisciplinary treatment teams. However, clinicians did not document that they advised patients and families of their due process discharge appeal procedures.

OFFICE OF MANAGEMENT AND ADMINISTRATION

Hotline

The Hotline program provides an opportunity for employees, veterans, and other concerned citizens to report fraud, waste, abuse, and mismanagement. The identification and reporting of issues such as these are integral to the goal of improving the efficiency and effectiveness of the Government. During the reporting period, the Hotline received 8,319 contacts. We opened 537 cases, and closed 461 cases which contained 204 substantiated allegations. Hotline staff responded to 139 inquiries received from members of the Senate and House of Representatives. The cases we opened led to 46 administrative sanctions against employees and 75 corrective actions taken by management to improve VA operations and activities. Our reviews identified: (i) employees and contractors who abused time and leave; (ii) supervisors who abused their authority and accepted gifts from subordinates; (iii) several instances of misconduct by medical staff in the care and treatment of veteran patients; and (iv) problems in VBA operations with a number of compensation and pension cases that warranted corrective action by management.

Follow Up on OIG Reports

The Operational Support Division tracks implementation actions on issued audits, inspections, and reviews with over $946 million of actual or potential monetary benefits as of September 30, 2000. Of this amount, $857 million is resolved as VA officials have agreed to implement the recommendations, but have not yet done so. In addition, $89 million relates to unresolved reviews awaiting contract resolution by VA contracting officers. After obtaining information that showed VA officials had fully implemented corrective actions, the Division took action to close 67 internal reports and 279 recommendations with a monetary benefit of $65 million.

Status of OIG Reports Unimplemented for Over 3 Years

VA management officials are required to provide the OIG with documentation showing the completion of corrective actions taken on OIG reports. In the majority of cases, program offices provide us with the actions required to implement the reports in a reasonable period. However, we are concerned about five OIG reports that were issued in FY 97 and earlier that remain unimplemented. VHA has three reports (one report issued in each of FYs' 94, 96, and 97), and VBA has two reports (both issued in FY 97).

VA AND OIG MISSION, ORGANIZATION, AND RESOURCES

The Department of Veterans Affairs (VA)

Background

In one form or another, American governments have provided veterans benefits since before the Revolutionary War. VA's historic predecessor agencies demonstrate our Nation's long commitment to veterans.

The Veterans Administration was founded in 1930, when Public Law 71-536 consolidated the Veterans' Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers.

The Department of Veterans Affairs was established on March 15, 1989, by Public Law 100-527, which elevated the Veterans Administration, an independent agency, to Cabinet-level status.

Mission

VA's motto comes from Abraham Lincoln's second inaugural address, given March 4, 1865, "to care for him who shall have borne the battle and for his widow and his orphan." These words are inscribed on large plaques on the front of the VA Central Office building on Vermont Avenue in Washington, DC.

The Department's mission is to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to this Nation.

810 Vermont Avenue

[picture not available]

810 Vermont Avenue, NW, Washington, DC

Organization

VA has three administrations that serve veterans:

- Veterans Health Administration (VHA) provides health care,
- Veterans Benefits Administration (VBA) provides benefits, and
- National Cemetery Administration (NCA) provides interment and memorial services.

To support these services and benefits, there are six Assistant Secretaries:

- Management (Budget, Finance, Acquisition and Materiel Management),
- Information and Technology,
- Policy and Planning,
- Human Resources and Administration (Equal Opportunity, Human Resources Management, Administration, Security and Law Enforcement, and Resolution Management),
- Public and Intergovernmental Affairs, and
- Congressional Affairs.

In addition to VA's Office of Inspector General, other staff offices providing support to the Secretary include the Board of Contract Appeals, the Board of Veterans' Appeals, the Office of General Counsel, the Office of Small and Disadvantaged Business, the Centers for Minority Veterans and for Women Veterans, and the Office of Employment Discrimination Complaint Adjudication.

Resources

While most Americans know that VA exists, few have any idea of the size of the Department, which is the Nation's second largest in terms of staffing. For FY 2000, VA had a $45.5 billion budget and approximately 202,600 employees. There are an estimated 25.9 million living veterans. To serve our Nation's veterans, VA maintains facilities in every state of the union, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Philippines.

Approximately 186,000 of VA's employees work in the health care system. Health care is funded at $19.6 billion, approximately 43 percent of VA's budget in FY 2000. VHA provides care to an average of 58,100 inpatients daily. During FY 2000, slightly more than 40 million episodes of care are estimated for outpatients. There are 172 hospitals, 766 outpatient clinics, 132 nursing home units, and 40 domiciliaries.

Veterans benefits are funded at $24.8 billion, almost 55 percent of VA's budget in FY 2000. The 11,300 employees of VBA provide benefits to veterans and their families. Approximately 2.6 million veterans and their beneficiaries receive compensation benefits valued at $19 billion. Also, over $3 billion in pension benefits are provided to veterans and survivors. VA life insurance programs have 4.5 million policies in force with a face value of over $450 billion. Almost 280,000 home loans will be guaranteed in FY 2000, with a value of almost $32 billion.

The National Cemetery Administration currently operates and maintains 119 cemeteries with approximately 1,400 employees in FY 2000. Operations of NCA and all of VA's burial benefits account for approximately $300 million of VA's $45.5 billion budget. Interments in VA cemeteries continue to increase each year, with 83,300 estimated for FY 2000. Approximately 343,000 headstones and markers will be provided for veterans and their eligible dependents in VA and other Federal cemeteries, state veterans' cemeteries, and private cemeteries.

VA Office of Inspector General (OIG)

Background

VA's OIG was administratively established on January 1, 1978, to consolidate audit, investigation, and related operations into a cohesive, independent organization. In October 1978, the Inspector General Act (Public Law 95-452) was enacted, establishing a statutory Inspector General (IG) in VA.

Role and Authority

The Inspector General Act of 1978 states that the IG is responsible for: (i) conducting and supervising audits and investigations; (ii) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect fraud and abuse in, the programs and operations of VA; and (iii) keeping the Secretary and the Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action.

The Inspector General Act Amendments of 1988 provided the IG with a separate appropriation account and a revised and expanded procedure for reporting semiannual workload to Congress. The IG has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements. The inquiries may be in the form of audits, investigations, inspections, or other appropriate actions.

Organization

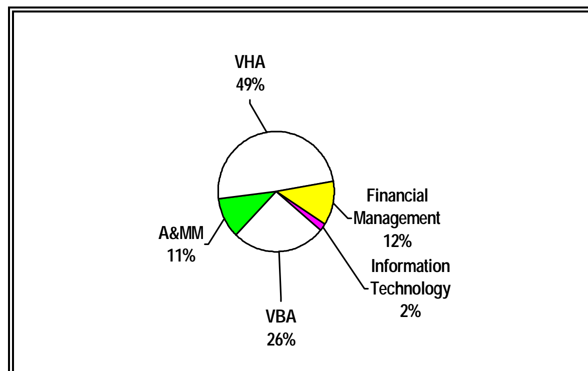
Allocated full time equivalent (FTE) for the FY 2000 staffing plan was as follows:

OFFICE	ALLOCATED FTE
Inspector General	4
Counselor	5
Investigations	108
Audit	166
Management and Administration	52
Healthcare Inspections	34
TOTAL	**369**

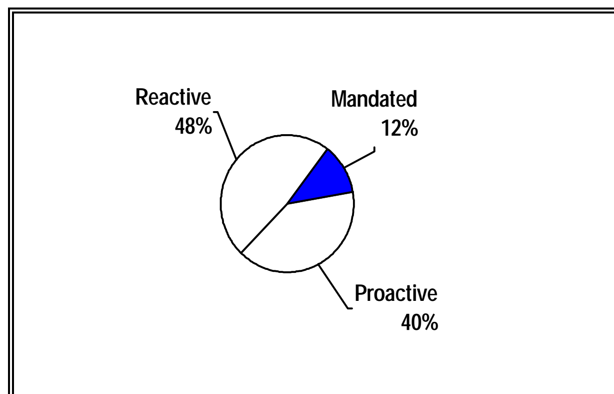
In addition, 24 FTE are reimbursed for a Department contract review function.

FY 2000 funding for OIG operations was $45.4 million, with $43.2 million from appropriations and $2.2 million through reimbursable agreements. Approximately 72 percent of the total funding was for salaries and benefits, 6 percent for official travel, and the remaining 22 percent for all other operating expenses such as contractual services, rent, supplies, and equipment.

The percent of OIG resources, which have been devoted during this semiannual reporting period in VA's major organizational areas, are indicated in the following chart.



The following chart indicates the percent of OIG resources which have been devoted to mandated, reactive, and proactive work.

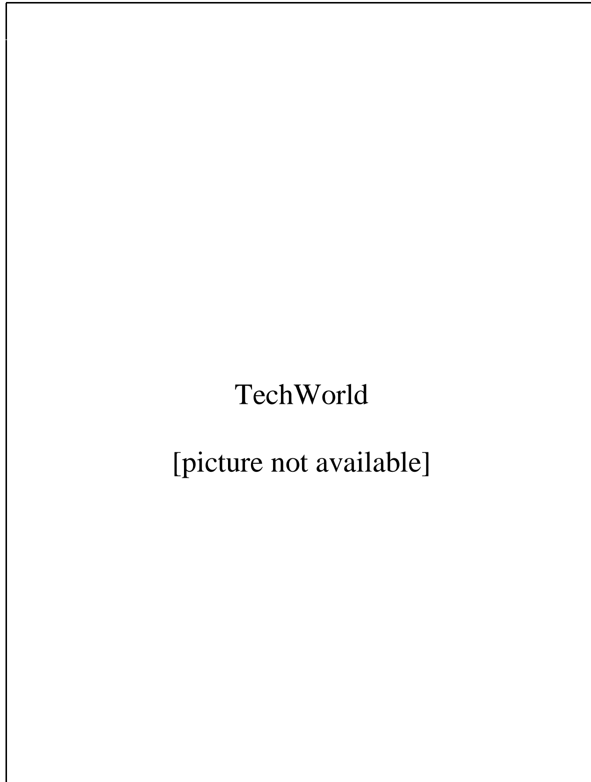


Mandated work is required by law and the Office of Management and Budget (OMB); examples are our audits of VA's consolidated financial statements, follow up activities, and Freedom of Information Act information releases.

Reactive work is generated in response to requests for assistance received from external sources concerning allegations of fraud, waste, abuse, and mismanagement. Most of the work

performed by the Offices of Investigations is reactive.

Proactive work is self-initiated, focusing on areas where the OIG staff determines there are significant issues; some healthcare inspections and most audits fall into this category.


TechWorld

[picture not available]

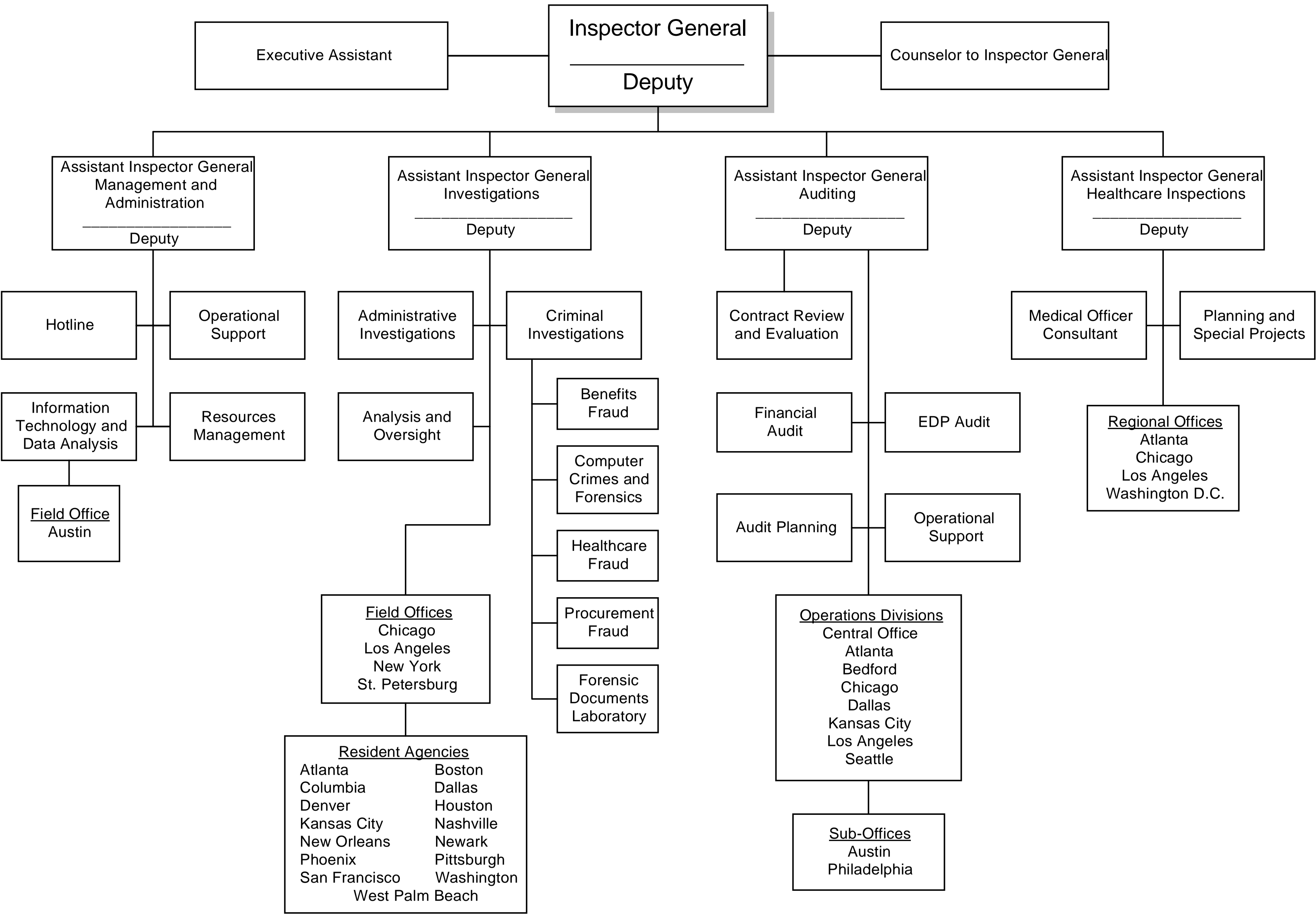
TechWorld, home to the VA Office of Inspector General

OIG Mission Statement

The OIG is dedicated to helping VA ensure that veterans and their families receive the care, support, and recognition they have earned through service to their country. The OIG strives to help VA achieve its vision of becoming the best managed service delivery organization in Government. The OIG continues to be responsive to the needs of its customers by working with the VA management team to identify and address issues that are important to them and the veterans served.

In performing its mandated oversight function, the OIG conducts investigations, audits, and health care inspections to promote economy, efficiency, and effectiveness in VA activities, and to detect and deter fraud, waste, abuse, and mismanagement. The OIG's oversight efforts emphasize the goals of the National Performance Review and the Government Performance and Results Act (GPRA) for creating a Government that works better and costs less. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer driven and results oriented.

The OIG will keep the Secretary and the Congress fully and currently informed about issues affecting VA programs and the opportunities for improvement. In doing so, the staff of the OIG will strive to be leaders and innovators, and perform their duties fairly, honestly, and with the highest professional integrity.


DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
Inspector General
Deputy
Executive Assistant
Counselor to Inspector General
Assistant Inspector General Management and Administration
Deputy
Hotline
Operational Support
Information Technology and Data Analysis
Resources Management
Field Office
Austin
Assistant Inspector General Investigations
Deputy
Administrative Investigations
Criminal Investigations
Analysis and Oversight
Benefits Fraud
Computer Crimes and Forensics
Healthcare Fraud
Procurement Fraud
Forensic Documents Laboratory
Field Offices
Chicago
Los Angeles
New York
St. Petersburg
Resident Agencies
Atlanta
Columbia
Denver
Kansas City
New Orleans
Phoenix
San Francisco
Boston
Dallas
Houston
Nashville
Newark
Pittsburgh
Washington
West Palm Beach
Assistant Inspector General Auditing
Deputy
Contract Review and Evaluation
Financial Audit
EDP Audit
Audit Planning
Operational Support
Operations Divisions
Central Office
Atlanta
Bedford
Chicago
Dallas
Kansas City
Los Angeles
Seattle
Sub-Offices
Austin
Philadelphia
Assistant Inspector General Healthcare Inspections
Deputy
Medical Officer Consultant
Planning and Special Projects
Regional Offices
Atlanta
Chicago
Los Angeles
Washington D.C.

COMBINED ASSESSMENT PROGRAM

Combined Assessment Program Overview

The Combined Assessment Program (CAP) is part of the OIG's effort to ensure that quality health care service is provided to our Nation's veterans. The CAP provides cyclical oversight of VA medical facility operations; focusing on the quality, efficiency, and effectiveness of service provided to veterans.

The CAP combines the skills and abilities of the OIG's major components to provide collaborative assessments of VA medical facilities. The OIG team consists of representatives from the Offices of Investigations, Audit, and Healthcare Inspections. They provide an independent and objective assessment of key operations and programs at VAMCs on a cyclical basis.

Special agents from the Office of Investigations conduct fraud and integrity awareness briefings. The purpose of these briefings is to provide key staff of the VAMC with insight into the types of fraudulent activities that can occur in VA programs. The briefings include an overview and case-specific examples of fraud affecting health care procurements, false claims, conflict of interest, bribery, and illegal gratuities. Special agents also investigate certain matters which have been referred to the OIG by VA employees, members of Congress, veterans, and others.

Auditors from the Office of Audit conduct a limited review to ensure that management controls are in place and working effectively. Auditors assess key areas of concern which are derived from a concentrated and continuing analysis of VHA, VISN, and VAMC databases and management information. These areas may include patient management, credentialing and privileging, agent cashier activities, data integrity, and the medical care cost fund.

Representatives from the Office of Healthcare Inspections conduct proactive reviews which incorporate the use of standardized survey instruments. The reviews evaluate care provided in VA health care facilities and procedures for ensuring the appropriateness and safety of patient care. The facilities are evaluated to determine the extent to which they are contributing to VHA's ability to accomplish its mission of providing high quality health care, improved patient access to care, and high patient satisfaction.

The following is a summary of the 14 CAP reports completed this period. It includes highlights of our activities and areas that we identified as vulnerable and in need of greater management attention. During these 14 on-site CAP visits, the Office of Investigations conducted 88 fraud and integrity briefings for approximately 2,600 employees attending.

VA Medical Center Omaha

Patient Care and Quality Management (QM) Review - The VAMC had a comprehensive QM program that includes national and local performance measures. The clinical program review identified various issues that required management attention. We recommended the VAMC: (a) improve communication about quality and performance improvement activities between the quality council and the executive committee of the medical staff; (b) assess waiting times for ambulatory care, specifically primary care, cardiology clinic, pain clinic, prescription filling, and radiology studies; (c) improve patient transfers and referral from other facilities in the Greater Nebraska Healthcare System; (d) improve the primary care process to ensure that all patients have an assigned primary

care provider; (e) improve patient transition from inpatient specialty care, such as surgery, to primary care; (f) take action to correct the physical environmental concerns in the operating room; and (g) review the effectiveness of the home glucose-monitoring program, including documentation, education, and quality control.

Management Control Issues - The VAMC's financial and administrative activities were generally operating satisfactorily and controls were effective. We identified a number of areas where management control could be strengthened. Specific areas needing improvement included: (a) enhance the fee-basis program, (b) enhance medical transportation services, (c) improve the purchase card program, (d) enhance controlled substances security, (e) improve security of information systems, and (f) enhance agent cashier controls.

The Director agreed to address the areas of concern and provided specific plans for corrective action. *(CAP Review, Department of Veterans Affairs Medical Center, Omaha, NE, 00-00025-37, 04/03/00)*

Carl T. Hayden VA Medical Center Phoenix

Patient Care and QM Review - The VAMC had a comprehensive QM program that effectively coordinated patient care activities and provided strong oversight of the quality of care. We made two recommendations to improve patient care management. First, stronger controls were needed to ensure that problematic bedside glucose test results were referred for laboratory analysis as required by VAMC policy. Second, management needed to address several issues and concerns pertaining to the patient care environment, staffing, and medical records.

Financial and Administrative Management - The VAMC's financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve controls, we recommended that the VAMC: (a) reduce excess supply inventories, (b) strengthen timekeeping for part-time surgeons, (c) perform required annual equipment inventories, (d) improve collection of vendor accounts receivable, (e) include expired drugs in controlled substances inspections, and (f) ensure that signed means test forms are obtained from patients.

The Director concurred with the findings and recommendations and provided acceptable implementation plans. *(CAP Review, Carl T. Hayden VAMC, Phoenix, AZ, 0001072-64, 5/4/00)*

VA Medical Center Denver

Patient Care and QM Review - VAMC management created an environment that supported QM and performance improvement. The VAMC had a comprehensive, well-organized QM program that effectively coordinated patient care activities and provided strong oversight of the quality of care. We made recommendations for VAMC management to review and take appropriate action on various patient care issues and concerns, to include: (a) securely storing and properly labeling medications, (b) correcting potential safety hazards in a psychiatric unit, (c) improving medication error data collection, and (d) performing tuberculosis screening for certain high-risk patients.

Financial and Administrative Management - The VAMC's financial and administrative activities were generally operating satisfactorily and controls were generally effective. To improve controls, we recommended the VAMC: (a) obtain better pricing data and improve performance monitoring for clinical services contracts, (b) transfer purchase card coordinator duties, (c) reduce supply inventories, (d) include

expired drugs in controlled substances inspections, (e) pursue collection of delinquent accounts receivable, (f) improve reviews of unliquidated obligations, and (g) strengthen information technology security by providing training to employees and by designating an alternative computer processing site.

The Medical Center Director concurred with the findings and recommendations and provided acceptable implementation plans. *(CAP Review, VAMC Denver, CO, 00-00473-63, 5/4/00)*

> **"The OIG conducted the review in a highly efficient and effective manner that included close coordination with the Medical Center. This allowed for a comprehensive review of numerous important activities with minimal disruption to our operations. We have found the findings and recommendations reasonable and useful in our efforts to improve our systems for the delivery of safe, quality, and fiscally responsible health care."**
>
> **Director**
> **VAMC Denver**

VA Northern Indiana Health Care System, Fort Wayne and Marion

Patient Care and QM Review - The QM review identified areas of concern that affected the quality of care. The report discusses: (a) long term care; (b) the facility treatment environment; (c) quality management and performance improvement issues; (d) medication policy, availability, and security; (e) patient care services; and (f) employee assistance program and training.

Financial and Administrative Management - The VAMC's financial and administrative activities were generally operating satisfactorily and management controls were generally effective. We made recommendations in the following areas: (a) community based outpatient clinic management, (b) accountability and security over controlled substances, (c) radiology services contracting, (d) laboratory service staffing, (e) informed consent for surgery, (f) reviews of state of Indiana administration and oversight of contract community nursing homes, (g) medical supplies inventory controls, (h) supply processing and distribution operations, (i) agent cashier audits, (j) controls over third-party payer checks, (k) information technology systems access, and (l) monitoring the drug prescription backlog.

The Director concurred with the findings and recommendations and provided acceptable implementation plans. *(CAP Review, VA Northern Indiana Healthcare System, Ft. Wayne and Marion, IN, 00-01199-72, 5/25/00)*

VA Medical and Regional Office Center (VAMROC) White River Junction

Patient Care and QM Review - While we concluded that the VAMROC had a comprehensive QM program in place, we identified opportunities to further enhance its effectiveness. We also identified several issues that required increased management attention to ensure high quality patient care. To further enhance patient care quality management, we recommended the VAMROC: (a) improve focused reviews/root cause analyses, (b) ensure patient concerns are addressed in a timely and efficient manner, (c) document informed consent, (d) ensure that ambulatory care patients obtain ordered follow up services, (e) monitor prescribing practices for elderly and chronic pain patients, (f) improve oversight of contract and state nursing home patients, (g) monitor clinic utilization, (h) improve patient waiting

times, (i) enhance the safety of patients who smoke, (j) improve the appearance of patient care areas, (k) replace outdated radiology equipment, (l) establish a viable surgical service, and (m) resolve clinical staffing needs.

Financial and Administrative Management - The VAMROC's financial, administrative, and benefit program activities were generally operating satisfactorily and management controls were generally effective. To improve controls over medical center activities, we recommended the VAMROC: (a) reduce excess medical supplies inventory costs, (b) improve billing procedures for inpatient care, (c) pursue collection of delinquent debts, (d) strengthen narcotic inspections, (e) improve research corporation accounting controls, and (f) address employee concerns regarding the recognition and awards program.

Regional Office Program Operations - To improve controls over regional office activities, we recommended the VAMROC: (a) improve security over automated information systems, (b) strengthen controls over benefit adjustments for veterans receiving long-term care at VA expense, and (c) ensure that vocational rehabilitation and employment service improves initial claims processing.

The Director concurred with the recommendations and findings and provided acceptable implementation plans. *(CAP Review, VA Medical and Regional Office Center, White River Junction, VT, 00-01062-84, 6/5/00)*

VA Gulf Coast Veterans Health Care System, Biloxi and Gulfport

Polarization of Staff and Management - There was significant change in the top management in the past 2 years including the assignment of a new medical center Director, Chief of Staff, and Associate Director for Patient Care Services/Nurse Executive. Also, after functioning for approximately 3 years organized by product lines, they have reorganized to a more traditional service/department organization. The net result of the many organizational changes and differing philosophies regarding the right approach to patient care and competing priorities has polarized many staff and patients. We recommended that management develop a system to address employee perceptions and concerns regarding quality of care, work environment, and personnel practices.

Patient Care and QM Review - We identified several issues that required increased management attention to ensure high quality patient care. We made recommendations in the following areas: (a) clinical staffing, (b) quality management program, (c) ambulatory care, and (d) community nursing homes.

Financial and Administrative Management - We concluded that overall, the medical center generally maintained an effective system of internal controls in the 14 areas we reviewed and tested. We made recommendations in the following areas: (a) contracting for radiologists, (b) inventory of medical supplies, (c) food preparation, (d) employee receivables, (e) Government purchase card, (f) agent cashier, and (g) third-party receivables.

The Director agreed with the findings and recommendations and provided acceptable implementation plans. *(CAP Review, VA Gulf Coast Veterans Health Care System, Biloxi and Gulfport, MS, 00-00933-88, 6/19/00)*

VA Central California Health Care System, Fresno

Patient Care and QM Review - Management created an environment that supported quality patient care and performance improvement. There is also a comprehensive QM program that provided strong oversight of the quality of care.

To improve patient care management, the facility needed to: (a) perform required inspections of contract nursing homes; (b) complete medical records more promptly, reduce the backlog of unfiled medical record documents, and ensure that medical records are securely stored; and (c) address various patient care environment, staffing, and appointment scheduling issues.

Financial and Administrative Management - The financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve controls, the facility needed to: (a) reduce medical and engineering supply inventories, (b) strengthen information technology security by promptly deactivating unneeded user access to information systems and by designating an alternative computer processing site, (c) include expired drugs in controlled substances inspections, (d) reconcile accounts receivable and pursue delinquent debts, and (e) ensure that signed means test forms are obtained from patients.

The Director agreed with the CAP review findings and recommendations and provided acceptable plans to take corrective action. *(CAP Review, VA Central California Health Care System, Fresno, CA, 00-01227-94, 7/14/00)*

VA New York Harbor Healthcare System, Brooklyn and Manhattan

Patient Care and QM Review - A comprehensive QM program is in place that effectively coordinated patient care activities and provided strong oversight of the quality of care. We identified several opportunities to further improve patient care services and quality management. Management was in the process of addressing, or agreed to take appropriate action on, various patient care issues and concerns, including: (a) improving the patient care environment in some inpatient areas and wards, (b) improving pharmacy services, (c) improving mental health services, (d) addressing staffing needs, and (e) improving medical records documentation.

Financial and Administrative Management - Financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To further improve operations, we recommended that management: (a) reduce supply inventories, (b) improve controls over the purchase card program, (c) ensure required means tests are properly completed, (d) improve inspections of community nursing homes, and (e) improve information technology security. We also identified opportunities for management to: (a) improve reviews of unliquidated obligations, (b) enhance collection of delinquent debts, (c) improve controls over the contract beneficiary transportation program, (d) strengthen the timeliness and thoroughness of controlled substance inspections, and (e) ensure printing services are properly obtained.

The Director concurred with the findings and recommendations and provided acceptable implementation plans. *(CAP Review, VA New York Harbor Healthcare System, Brooklyn and Manhattan, NY 00-01223-104, 8/3/00)*

William Jennings Bryan Dorn Veterans' Hospital, Columbia

Patient Care and QM Review - We found that appropriate monitors were in place and effectively working. We identified opportunities to improve: (a) access to outpatient care, (b) access to care in the primary and specialty clinics, (c) inpatient medical record documentation, (d) design and allocation of space in the physical medicine and rehabilitation clinic, (e) nursing proficiency evaluations, (f) security issues in the mental health building, and (g) restorative nursing therapy and patient participation in structured therapies in the nursing home care unit.

Financial and Administrative Management - Overall, the medical center generally maintained an effective system of internal controls in the areas we reviewed. We recommended that management develop a measurable statement of work for the surgical service contract. We identified minor deficiencies and made suggestions for improvements in six areas: (a) contracted otolaryngology services, (b) Government purchase card program, (c) means test certifications, (d) unannounced audits of the agent cashier, (e) pharmacy service security, and (f) third-party reimbursable insurance accounts receivable.

The Director concurred with the findings and recommendations and provided acceptable implementation plans. *(CAP Review, William Jennings Bryan Dorn Veterans' Hospital, Columbia, SC, 00-01202-107, 8/18/00)*

VA Medical Center Portland

Patient Care and QM Review - VAMC management had created an environment that supported quality patient care and performance improvement. The VAMC had a comprehensive QM program that provided strong oversight of the quality of care. To improve patient care management, the VAMC needed to: (a) perform required inspections of contract nursing homes, (b) reduce the backlog of unfiled medical record documents, and (c) address several issues and concerns pertaining to the patient care environment, staffing, and waiting times.

Financial and Administrative Management - The VAMC's financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve controls, the VAMC needed to: (a) strengthen timekeeping for part-time physicians; (b) improve collection of medical care cost fund receivables; (c) ensure that signed means test forms are obtained from patients; (d) reduce excess supply inventories; and (e) inspect all controlled substances storage areas monthly, including expired drugs.

The Medical Center Chief Executive Officer concurred with the findings and recommendations and provided acceptable implementation plans. *(CAP Review, VAMC Portland, OR, 00-1217-105, 8/18/00)*

VA Medical Center Tuscaloosa

Patient Care and QM Review - We found that appropriate patient care and QM monitors were in place and effectively working. We made suggestions in six patient care areas to: (a) eliminate the medical acute care unit and redirect critically ill patients to other medical facilities, (b) restructure the residential program to better support mental health treatment, (c) ensure that clinicians record treatment activities in the medical record, (d) ensure timely and accurate tray preparation and improve quality control in nutrition service, (e) contract for additional community nursing home beds, and (f) improve timeliness and documentation of contract care inspection team activities. We also made suggestions for two treatment environment issues to ensure that wardrobes in patient rooms in building 61 were secured to the wall to prevent injury and to arrange for emergency communications by patients and visitors in connecting tunnels.

Financial and Administrative Management - The VAMC's financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve operations, we made suggestions to: (a) pursue the opportunity to establish a centralized food processing center, (b) address contracting issues for leased space for non-Federal use, (c) ensure that the canteen dining area is kept clean, (d) address inappropriate sales of cigarettes by canteen service, (e) dispose of unusable drugs quarterly rather than semiannually, and (f) enhance various aspects of

the agent cashier function. We also made recommendations to develop more detailed automated information system contingency plans, and improve controls over inventory management.

The Medical Center Director concurred with the findings and recommendations and provided acceptable implementation plans. *(CAP Review, VAMC Tuscaloosa, AL, 00-02003-108, 8/18/00)*

VA Medical Center Hampton

Patient Care and QM Review - Appropriate patient care and QM monitors were in place and effectively working. We made suggestions to: (a) ensure that clinicians properly and accurately record the services that they provide, (b) decrease waiting times in the gastroenterology and neurology clinics, (c) increase gynecology attendant services in the women veterans' treatment program, (d) secure medications and supplies in the emergency room, (e) install additional panic buttons in mental health service, (f) provide the compensated work therapy van driver with emergency communications equipment, (g) fill pharmacist vacancies and provide medication bar coding training prior to implementing 24-hour coverage, and (h) revise competency assessment checklists for addiction specialists. We also made suggestions to resolve ward 2N solarium environmental deficiencies, and provide for a consistent smoking policy throughout the facility.

Financial and Administrative Management - The VAMC's financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve operations, we made suggestions to: (a) turn in excess research equipment, (b) assess monitoring of approvals for information technology equipment, (c) address internal control issues in the purchase card program, (d) follow guidelines for approving and reporting commercial printing costs, (e) improve community nursing home inspections, and (f) conduct random audits of the agent cashier. We also made recommendations to pursue reducing community nursing home rates, improve controls over controlled substances, improve administration over research consent forms, and reduce the agent cashier's advance.

The Director concurred with the findings and recommendations and provided acceptable implementation plans. *(CAP Review, VAMC Hampton, VA, 00-1225-109, 8/31/00)*

VA North Texas Health Care System, Dallas and Bonham

Patient Care and QM Review - While we concluded that the system had a comprehensive quality management program in place, we identified some opportunities to further enhance its effectiveness. We also identified several issues that required increased management attention to ensure high quality patient care. These issues include: (a) waiting times for prescribed medications, (b) delays in obtaining specialty clinic appointments, (c) adequacy of the computer system, (d) adequacy of facilities for the treatment of mental health patients, (e) cleanliness in certain areas, (f) patient privacy in consultation rooms, (g) preparation of surgical instrument trays, (h) perceptions of the employee recognition and awards program, (i) documentation of treatment goals, (j) documentation of informed consent, and (k) documentation of actions taken in response to recommendations by a board of investigation.

Financial and Administrative Management - Overall, the system maintained effective financial and administrative controls. For most controls tested, we identified only minor deficiencies. Areas which require greater management attention include: (a) security measures at the Bonham facility, (b) reconciliation and approval of purchase card transactions, (c) medical supply inventories, (d)

access to information systems, (e) documentation of means tests, (f) controls over time and attendance reporting, and (g) accrued services payable and undelivered orders.

The system Director concurred with the recommendations and provided acceptable implementation plans. *(CAP Review, VA North Texas Health Care System, 00-01065-117, 9/8/00)*

> **"… VANTHCS was appreciative of the constructive approach taken by each member of the OIG team during the review. The review proved to be informative and has provided VANTHCS recommendations that will further improve quality care and service to our veterans. "**
>
> **Director, VA North Texas Health Care System**

VA Western New York Healthcare System, Buffalo and Batavia

Patient Care and QM Review - The system had demonstrated a strong commitment to quality management and performance improvement. However, we identified a number of opportunities to further improve patient care services and quality management. These issues and concerns include: (a) ensuring that medical records are promptly completed and securely stored, (b) properly documenting informed consents for surgical procedures, (c) ensuring compliance with VHA patient safety directive, (d) assessing staffing needs in post-traumatic stress syndrome and long-term care programs, (e) ensuring that nurses properly record patient pain level assessments, (f) improving clinical appointment timeliness, and (g) enhancing management oversight of the patient care environment.

Financial and Administrative Management - Financial and administrative activities were generally operating satisfactorily and controls were generally effective. Management could further improve operations by: (a) reducing excess medical supply inventories, (b) strengthening controls over the purchase card program, (c) improving information technology security, (d) strengthening controls over the means test program, (e) ensuring inpatient episodes of care are appropriately billed, (f) strengthening controlled substance inspections, (g) strengthening controls over the contract beneficiary transportation program, and (h) improving sharing agreement negotiations.

The Director concurred with the recommendations and provided acceptable implementation plans. *(CAP Review, VA Western New York Healthcare System, Buffalo and Batavia, NY, 00-01230-120, 9/25/00)*

OFFICE OF INVESTIGATIONS

Mission Statement

> ***Conduct investigations of criminal activities and administrative matters affecting the programs and operations of VA in an independent and objective manner, and assist the Department in detecting and preventing fraud and other violations.***

The Office of Investigations is responsible for conducting criminal and administrative investigations affecting the programs and operations of VA. The office consists of three divisions.

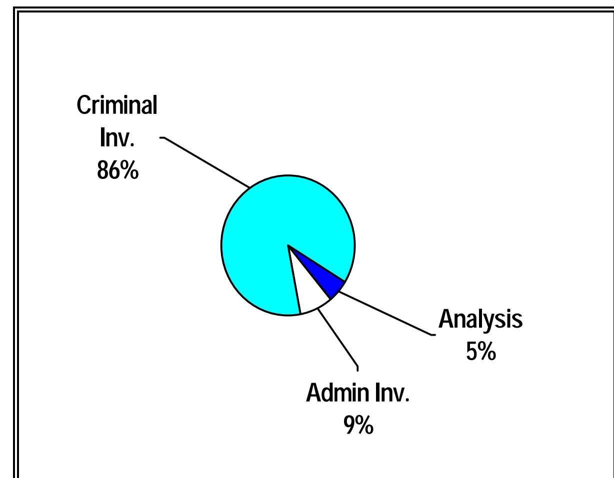
I. Criminal Investigations Division - The Division is primarily responsible for conducting investigations into allegations of criminal activities related to the programs and operations of VA. Criminal violations are referred to the Department of Justice for prosecution. The Division is also responsible for operation of the forensic document laboratory.

II. Administrative Investigations Division - The Division is responsible for investigating allegations, generally against high-ranking VA officials, concerning misconduct and other matters of interest to the Congress and the Department.

III. Analysis and Oversight Division - The Division is responsible for the oversight responsibilities of all Office of Investigations operations through a detailed, recurring inspection program. The Division is the primary point of contact for law enforcement communications through the National Crime Information Center, the National Law Enforcement Telecommunications System, and the Financial Crimes Criminal Enforcement Network.

Resources

The Office of Investigations has 115 FTE allocated to the following areas.



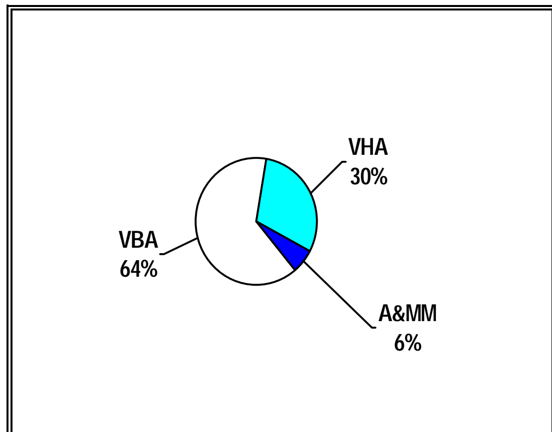
I. CRIMINAL INVESTIGATIONS DIVISION

Mission Statement

> ***Conduct investigations of criminal activities affecting the programs and operations of VA in an independent and objective manner, and assist the Department in detecting and preventing fraud and other criminal violations.***

Resources

The Criminal Investigations Division has 96 FTE for its headquarters and 19 field locations. These individuals are deployed in the following program areas:



Overall Performance

Output

- 316 investigations were concluded during the reporting period. We met the performance goal for output.

Outcome

- Arrests - 174
- Indictments - 156
- Convictions - 122
- Monetary benefits - $13.9 million ($7.2 million - fines, penalties, restitutions, and civil judgements; $5.0 million - efficiencies/funds put to better use; and $1.7 million - recoveries)
- Administrative sanctions - 138

Cost Effectiveness

- The average cost of conducting the 316 closed investigations was $4,031. Each investigation averaged a return of $35,939, resulting in approximately $9 returned for every $1 spent.

Timeliness

- Average work days from receipt of allegation to initiation of investigation averages 42 days against a goal of 30 days.
- Average work days from initiation of investigation to referral to an Assistant U.S. Attorney was 7.1 months versus our goal of 6 months.

Customer Satisfaction

- Customer satisfaction survey forms were provided to each prosecutor upon referral of an investigation for criminal prosecution. All ratings received exceeded 4.0 and averaged 4.7 out of a possible 5.0 (5.0 means highly satisfied and 1.0 means dissatisfied).

Following are summaries of some of the investigations conducted during the reporting period by VA component. We discuss VHA, VBA, Board of Veterans' Appeals, Office of Human Resources and Administration, and NCA. This is followed by the OIG forensic document laboratory summary.

Veterans Health Administration

Fraud and other criminal activities committed against VHA include actions such as patient abuse, theft of Government property, drug diversion, bribery/kickback activities by employees and contractors, false billings, and inferior products.

The Criminal Investigations Division investigates those instances of criminal activity against VHA that have the greatest impact and deterrent value. Working closely with VA police the office has placed an increased emphasis on crimes occurring at VA facilities throughout the nation to help ensure safety and security for those working in or visiting VA medical centers.

Employee Integrity

Theft/Diversion of Pharmaceuticals

- An individual employed as a pharmacist in the private sector was sentenced to 5 years' probation, a fine of $10,000, and restitution of $1,000 after a joint investigation by the VA OIG and a state board of pharmacy disclosed he had received pharmaceuticals stolen from a VAMC. The investigation showed an individual employed as a VAMC pharmacist stole the pharmaceuticals from the VA pharmacy and sold them to the private pharmacist at a discounted rate. The private pharmacist then placed the stolen pharmaceuticals in his drug store where they were sold at full retail rate. The VA pharmacist previously was sentenced and resigned from his VAMC position.

- A VAMC registered nurse was indicted on 13 counts of fraudulent acquisition of a controlled substance and 13 counts of theft of public property. The charges follow a joint investigation by the VA OIG and Drug Enforcement Administration (DEA) which disclosed the individual used his position to divert controlled substances from the VAMC pharmacy for his own use. As a result of the investigation, the individual was terminated from his employment.

- An individual employed as a VAMC laborer was sentenced in U.S. District Court to 300 months' imprisonment, 36 months' supervised release, and a $25,000 fine. He had previously pleaded guilty to two counts of using a minor to produce visual images of a minor engaged in sexual activity and to one count of possessing stolen Government property. The sentencing was the result of a joint investigation by the VA OIG, Federal Bureau of Investigations (FBI), and state and local law enforcement. It was disclosed that, during the course of his regular duties at the VAMC, the individual was in charge of the destruction of outdated or unused medications and drugs. He wrongfully removed some of these drugs from VA property, and covertly administered them to individuals to incapacitate them. The individual video taped the incapacitated individuals without their knowledge, in some cases sexually assaulting them. During the course of the investigation, the individual admitted to the production of the pornographic images as well as admitting to stealing various items from the VAMC, including a television and computer equipment. The value of the stolen items was estimated to exceed $110,000.

Ex-hospital worker gets
25-year term
for taping sex abuse

[picture not available]

"… this case could be used as a 'model' on how an investigation should be handled. … Through the collective efforts of all those involved in this case, a criminal of the worst variety has been removed from the streets for what will prove to be most of the remainder of his life. … On behalf of this office and the citizens of my district, let me express my thanks and gratitude to your agency… ."

United States Attorney,
Western District of Arkansas

- A former VAMC pharmacy technician pleaded guilty and was convicted on one count each of possession of dangerous drugs and possession for purposes of sale of prescription-only drugs. The individual was subsequently sentenced to 3 years' supervised probation, 60 days' imprisonment, a $2,000 fine, and ordered to complete 600 hours of community service. A joint investigation by the VA OIG, VA police, and local police disclosed the individual stole more than 20 different types of pharmaceuticals from the VA pharmacy and attempted to sell the drugs.

- A VAMC pharmacy technician was arrested at her residence by VA OIG special agents on charges of theft of Government property. At the time of her arrest the individual consented to a search of her residence, which revealed four shopping bags filled with pharmaceuticals and controlled substances stolen from the VAMC. The drugs had a value of more than $21,000. An additional consent search of her handbag uncovered VA pharmaceuticals valued at approximately $900, that she had taken on the day of her arrest. The individual agreed to cooperate in the investigation.

- A VAMC registered nurse resigned from his position pursuant to a joint VA OIG and VA police investigation into the diversion of controlled substances from a VA pharmacy. The joint investigation disclosed the individual diverted more than 60 doses of controlled substances from VA supplies for personal use. The investigation continues and criminal charges are pending.

- A VAMC registered nurse was indicted on three counts of drug diversion. A joint investigation by the VA OIG and the DEA disclosed the individual allegedly misrepresented herself to a physician at the VAMC by presenting her prescription profile with other VA patient's profiles. The physician proceeded to sign prescriptions for the nurse for her own personal use, believing that he was actually signing prescriptions for his patients.

- A registered nurse, formerly employed at a VA nursing home, surrendered to authorities in response to a criminal summons. He previously had been charged in a criminal information with theft of Government property after a VA OIG investigation disclosed the nurse engaged in a scheme to divert prescription narcotics from VA supplies for his own use. The individual diverted prescription drugs by recruiting VA nursing home patients who were willing to allow the nurse to take some of their as-needed medications, and by making fictitious entries on documentation associated with other patients. Over a 1-year period, the individual diverted more than 10,500 milligrams of liquid narcotics and more than 750 narcotic tablets. The criminal investigation continues.

- A former VAMC nurse was charged in a five-count criminal indictment with possession of prescription or dangerous drugs, criminal attempt to possess prescription or dangerous drugs, and forgery. A joint investigation by the VA OIG, U.S. Food and Drug Administration (FDA), local sheriffs, and VA police disclosed the former nurse contacted the VAMC and falsely claimed to be the wife of a veteran. By a scheme in which false information was provided to the VAMC, the former nurse improperly obtained prescription drugs.

Possession/Sale of Illegal Drugs

- A VAMC food service worker was sentenced to 1-year probation, and a second individual not employed by VA was sentenced to 3 years' supervised probation, after pleading guilty to one count each of possession of controlled substances. A VA OIG investigation disclosed both individuals engaged in the sale of controlled substances on VA property, including marijuana and cocaine. Over the course of a 6-month period, the VAMC employee engaged in

the selling of crack cocaine to an undercover informant on VAMC grounds.

- A VAMC compensated work incentive therapy program employee was arrested and indicted on charges of dealing illegal drugs on VAMC property. A joint investigation by the VA OIG and VA police disclosed the individual was also suspected of selling marijuana to other VA employees and patients. At the time of arrest on VA property, the individual was in possession of a large amount of cash and a substance believed to be marijuana. The investigation continues.

- Two VAMC employees, a housekeeper and a clerk, as well as two VAMC patients, one of whom was a compensated work therapy program participant, were arrested and charged with multiple counts of sale of narcotics. A joint investigation by the VA OIG and VA police disclosed the two patients sold their prescription narcotics to the two employees as well as to other patients and employees. In addition, the two employees sold prescription narcotics and marijuana on VAMC grounds.

Theft and Embezzlement

- A VAMC patient service assistant in the behavioral health office was arrested on charges of wrongfully accessing and misusing patient information. A joint investigation by the VA OIG and FBI disclosed the individual accessed the files of VAMC personnel and patients and obtained sensitive information from those files for the purpose of opening credit card accounts in the individuals' names without their knowledge. The scheme came to light after a number of individuals complained about charge accounts that had been opened in their names; accounts for which they had never applied. Investigation disclosed that a number of items had been mailed to the behavioral health office, where the employee was assigned. He became a suspect and was subsequently arrested after accepting delivery of personal items that had been charged to one of the suspect cards and sent to his office. He was charged with one count of theft, one count of receiving stolen property, one count of access device fraud, and one count of unlawful use of a computer. Additional charges are pending and the investigation continues.

- A former VAMC warehouse worker pleaded guilty to a one-count criminal information charging him with the theft of $20,000 in Government property. A joint investigation by the VA OIG, FBI, and Department of Defense (DoD) disclosed the individual stole VA computer equipment that was excessed to DoD and sold the equipment to an agent acting in an undercover capacity. When confronted with evidence of the transaction with the undercover agent, the individual chose to cooperate in the investigation and filed the guilty plea.

- A former VAMC environmental management service employee pleaded guilty to theft pursuant to a fraudulent scheme, and subsequently was sentenced to 3 years' supervised probation, and 100 hours' community service. Restitution in an unspecified amount, to be determined at a later time, has also been ordered. The guilty plea and sentencing are the result of a joint investigation by the VA OIG and VA police, which disclosed the individual used his position at the VAMC to wrongfully access patient identifying information, which he provided to a wireless telephone company employee, who in turn used the information to create new phone accounts. The VA employee then sold the accounts to others, including other VA employees, and profited from the scheme. The individual was terminated from employment.

- A VAMC custodian and clerk was convicted on charges of theft following a referral from the VAMC after they discovered a series of thefts of patient property dating as far back as 1994. A

VA OIG investigation disclosed the individual, who was responsible for check-in and storage of patient property as part of his duties, would return to the storage room after the property was checked-in to remove valuables and money from the patient property. The individual admitted during the course of the investigation that he had removed property from the storage room valued in excess of $8,000. A pre-sentence investigation was ordered and sentencing is pending. Based on his conviction, he was issued a letter of proposed removal from VAMC employment.

Workers' Compensation Benefits Fraud

- A former VAMROC nurse was convicted on charges of submitting a false statement to the Government in order to receive workers' compensation benefits to which she was not entitled. A joint investigation by the VA OIG and Department of Labor (DoL) OIG disclosed the individual submitted forms to DoL claiming she was unable to work due to an injury. However, she was earning income working at her husband's home improvement business. Her deception resulted in a loss to the Government of more than $60,000. Sentencing is pending.

- A summary judgement of $345,000 was entered in U.S. District Court against a former VAMC food service manager and his wife for making false statements made to collect Federal Employees Compensation Act benefits. A VA OIG investigation disclosed that after the individual allegedly suffered an on the job injury, for which he claimed workers' compensation benefits for an inability to work, he started running a limousine business. At the same time he continued to collect FECA benefits and did not report the employment to the DoL. The individual's wife, a former VAMC human resources employee, assisted her husband in making false statements on DoL forms. In previous judicial proceedings both the husband and wife pleaded guilty to criminal charges of workers' compensation benefits fraud.

Credit Card Fraud

- A former VAMC administrative clerk in the engineering service was arrested on charges of conspiracy to defraud the Government by allowing individuals to use Government credit cards for personal gain. A VA OIG investigation disclosed the individual conspired with two other individuals to steal VA credit cards and use them to purchase more than $10,000 in merchandise for personal use. The individual, who delivered the mail at the VAMC as part of her duties, intercepted the incoming credit card bills to avoid detection of the fraud by VAMC officials. The two other individuals, not employed by VA, were previously sentenced for their roles in the conspiracy.

- A former VAMC supervisory respiratory therapist was sentenced to 1 year supervised probation, 100 hours' community service, fined $500, and ordered to make restitution to VA of more than $4,900. The individual previously had pleaded guilty to a criminal information charging him with theft of Government funds after a joint investigation by the VA OIG and VA police disclosed he used a Government purchase card to buy over $4,900 worth of household appliances and other items for personal use. Pursuant to the investigation, he resigned from the VAMC.

- A VAMC environmental management service employee was accepted into a pre-trial diversion program after being indicted on charges of theft of Government property. A VA OIG investigation disclosed that, in the course of his regular duties, the individual used a Government-issued credit card to purchase supplies for the VAMC. The individual engaged in a scheme to return items he had purchased for the VAMC to various vendors and then directed the vendors not to refund the money back to the

Government credit card, but rather to send refund checks directly to his home. Investigation found that a total of six refund checks were sent to the employee's home. All were cashed and kept for personal use.

Assault and Threats Against Other VA Employees

- A former VAMC radiology technician was sentenced to 36 months' supervised probation after pleading guilty to one count of assault of a Federal employee. A joint investigation by the VA OIG and FBI disclosed the individual, who had previously been terminated from employment for insubordination and assaulting two other VA employees, made telephone threats to her former VAMC supervisor.

- A VAMC licensed practical nurse pleaded guilty to charges of introducing a firearm on Government property, was fined $500 and relieved of the weapon. The employee previously had been arrested and indicted following a VA OIG investigation which disclosed the employee had made threats of violence regarding his supervisor, claiming that he had the means to carry out the threats by possessing the weapon. A sentencing date is pending.

Patient Abuse

A former VAMC registered nurse was sentenced to 24 months' supervised probation and ordered to pay a court assessment after having pleaded guilty to charges of sexual abuse of a VA patient. The sentencing was the result of a joint investigation by the VA OIG and VA police into allegations that, over the course of 3 years, the individual engaged in non-permissive sexual conduct with patients in his care at the VAMC while performing patient care duties. The individual resigned in lieu of termination.

False Statements

- A former VAMC nursing assistant was sentenced to 5 years' probation and ordered to pay $10,152 in restitution after previously pleading guilty to submitting false claims to the Department of Housing and Urban Development (HUD) OIG. A joint investigation by the VA OIG and HUD OIG disclosed the individual falsely under-reported her salary, and forged the name of the chief of human resources at the VAMC on a HUD employment verification form, in order to gain rental benefits to which she was not otherwise entitled.

- A VAMC therapist was terminated from her position due to her personal involvement with a veteran who provided false income information to secure a VA guaranteed loan that went into default. The therapist, falsely claiming to be an assistant director of personnel, signed a VA form which stated the veteran was employed at the VAMC as a record auditor. The veteran was never employed at the VAMC, although he did receive medical care at the facility.

Other Employee Misconduct

- An individual employed in a VAMC morgue was sentenced to 3 months' home confinement, 2 years' probation, and a $200 fine. The individual previously had pleaded guilty to a four count criminal information charging him with assisting in the preparation of false income tax returns, conspiring to bribe a public official, conspiring to commit mail fraud, and filing false personal tax returns. A joint investigation by the VA OIG, DoL, and Internal Revenue Service (IRS) determined the individual engaged in the preparation and filing of more than 31 false tax returns during business hours at the VAMC morgue. In addition, investigation disclosed the individual misappropriated more than $190,000 in American Federation of Government Employees union funds from a union office located at the VAMC.

- A doctor was sentenced to 4 months' imprisonment and 36 months' supervised probation after pleading guilty to two counts of mail fraud. A joint investigation by the VA OIG and FBI disclosed the doctor, along with another doctor who faced separate charges and has already been sentenced, submitted false bills in order to receive insurance payments for elective cosmetic procedures not normally covered by insurance providers. A marketer in the scheme also was charged and pleaded guilty to mail fraud. The marketer acknowledged that several surgery centers paid her a commission to recruit patients, including VA employees, who were promised free plastic surgery procedures. Investigation revealed that marketers would refer patients to one of the surgery centers with the understanding that the center and doctors would bill the patients' insurance companies for the cosmetic surgeries. The marketers also would arrange for the patients' travel and hotel accommodations. In order to obtain payments for the cosmetic surgeries, the doctors falsely diagnosed the patients to justify the billings as "medically necessary" procedures. As part of the scheme, the two doctors also submitted bills that claimed they had been assisted by another surgeon during various procedures when, in fact, they never had any assistance.

- A former VAMROC police officer was sentenced to 12 months probation after pleading guilty to one count of false statements. A joint investigation by the VA OIG, Defense Criminal Investigative Service (DCIS), and VA police disclosed the individual falsely claimed his girlfriend to be his wife on official personnel documents in order for her to fraudulently obtain Government health insurance benefits to which she was not otherwise entitled. The individual resigned from his position while under investigation.

Theft/Diversion of Pharmaceuticals (non-employee)

- An individual was arrested and charged in a criminal complaint with conspiracy to steal VA pharmaceuticals after a VA OIG investigation disclosed the individual, a patient at a VAMC, conspired with VAMC pharmacy technicians to steal drugs for him. A trial date is pending and the investigation is continuing.

- An individual who was a patient at a VAMC pleaded guilty to forging prescriptions for controlled narcotics and obtaining controlled narcotics using an unlawful prescription. Subsequent to entering his guilty plea, the individual was sentenced to 3 months' incarceration and 3 years' probation. A joint investigation by the VA OIG and VA police determined the individual forged the name of a VAMC physician on multiple prescriptions, which he then used to obtain narcotics through the VAMC pharmacy.

- An individual pleaded guilty to charges of theft after being indicted on charges of stealing VA pharmaceuticals from the U.S. mail. A joint investigation by the VA OIG, VA police, and U.S. Postal Inspection Service disclosed that a Postal Service employee was responsible for the theft of VA pharmaceuticals that were being mailed to patients via a U.S. mail facility. The VA pharmaceuticals, which he kept for his own use, included large quantities of controlled substances and dangerous prescription medications, with a street value of $39,240. During the course of this investigation the individual admitted he had stolen the VA pharmaceuticals and voluntarily resigned as a mail handler. Sentencing is pending.

Possession of Illegal Drugs on VAMC Property

- An individual found to be in possession of illegal narcotics while undergoing care at a VAMC admitted to the illegal possession of the drugs and agreed to cooperate with authorities by turning in his drug supplier, an outpatient at the VAMC. Under the auspices of a joint VA OIG and VA police investigation, the individual contacted his drug supplier, agreeing to meet him on VAMC property in order to exchange prescription drugs for illegal narcotics. Both parties have agreed to further cooperation in the case, and the investigation continues.

- Two individuals were arrested and charged in a criminal complaint with possession with intent to distribute heroin at a VAMC. A joint investigation by the VA OIG and FBI disclosed the two individuals, who were patients at a VA methadone clinic, were selling heroin to other patients at the clinic. A trial date is pending.

2 Accused of
Heroin Sales to
Patients at Rehab Center

[picture not available]

Theft of Other Property

- An individual who had been a patient at a VAMC was arrested after failing to appear in U.S. District court for arraignment following a prior indictment on 21 counts of forgery of U.S. Treasury checks. A joint investigation by the VA OIG, U.S. Secret Service (USSS) and VA police disclosed the individual, who was once a patient at a VAMC, diverted forged and cashed civil service retirement benefits checks payable to another veteran patient at the VAMC who had a similar name. Investigation disclosed the other veteran patient, who was a long-term care patient at the VAMC, was moved in 1995 from the VAMC to a private nursing facility. At the time of the move, the Office of Personnel Management mailed a change of address form to the veteran patient at the VAMC in order to effect a change of address for his benefits checks. Because the veteran patient and the subject individual had similar names, the veteran patient's checks were inadvertently mailed to the home of the subject. The individual subsequently filed a formal change of address in order to continue receiving the retirement checks at his residence. The individual continued this scheme from July 1995 to March 1997, at which time the fraud was discovered when the veteran patient's family filed a claim for non-receipt of the checks. The individual diverted more than $14,200 in retirement benefits to which he was not entitled. A trial date is pending.

- An individual was sentenced to 15 years' incarceration, 5 years' probation, ordered to pay restitution of $5,600 to VA, and ordered to participate in a substance abuse treatment program after pleading guilty to charges of burglary and theft from a VA outpatient center. An accomplice also pleaded guilty and was subsequently sentenced to 5 years' incarceration and 3 years' probation. A joint investigation by the VA OIG, VA police, and local police disclosed the two individuals were responsible for burglaries committed at a VA outpatient

center and at local businesses. Computer equipment and other items were stolen.

- A VAMC canteen service volunteer pleaded guilty to one count of theft and was sentenced to 1-year probation and ordered to perform 80 hours of community service. A VA OIG investigation disclosed the individual had accessed a VAMC employee's office without her permission and removed blank money orders for $1,000 and $400 from the employee's purse. Within a half-hour of the theft, the individual negotiated the $1,000 money order.

- Five VAMC in-patients were arrested, indicted, pleaded guilty, and sentenced on charges of theft of telephone services. The five were sentenced to probation terms ranging from 18 to 24 months and ordered to pay restitution to VA. A joint investigation by the VA OIG and VA police disclosed the individuals conspired to fraudulently make long distance telephone calls by obtaining unauthorized access to a long distance personal identification number code belonging to a VAMC employee. Investigation disclosed the VAMC telephone system required that a code be used to dial long distance telephone calls. During a review of the computer program that tracks usage at the VAMC, it was discovered that several codes were being abused. All of the illegal usage was occurring at two hospital buildings, which housed the post-traumatic stress disorder program. A review revealed approximately $25,000 in fraudulent calls.

- A former patient, who had been given employment at a VAMC as part of his rehabilitation, pleaded guilty to three counts of selling cocaine and one count of theft of Government property. A second individual was arrested on charges of conspiracy to possess with intent to distribute crack cocaine. A joint investigation by the VA OIG, VA police, and DEA disclosed the patient/employee, who had been assigned work in the VAMC information resource management division, used his position controlling the inventory of computers to remove and sell computers and related items for personal gain. During the course of the investigation, an undercover agent purchased a quantity of drugs and approximately $30,000 in stolen VA computers from the patient/employee while on VAMC grounds. The second individual was arrested when the investigation disclosed that she was supplying the illegal drugs that were being sold by the patient/employee on VAMC property. Sentencing on both individuals is pending.

Credit Card Theft

An individual was sentenced to 12 months' imprisonment and 36 months' probation after pleading guilty to a criminal information charging him with the unauthorized and fraudulent use of a Government credit card. A VA OIG investigation disclosed the individual formerly was employed as a credit collection clerk at a medical supply company that did business with VA. As a clerk, the individual had been granted access to sensitive credit card information pertaining to Government, corporate, and private accounts. Investigation disclosed the individual used his access to the sensitive information to obtain and fraudulently use a Government credit card account number that was issued to a VAMC purchasing agent. The fraudulent transactions included the purchase of a computer, printer, and related software, which he had delivered to an out of state address.

Assault and Threats to VA Employees

A patient at a VAMC was arrested after threatening and verbally abusing VA police and VA medical staff. The individual, who has an extensive criminal record, including a prior

escape from Federal custody, was being held pending further judicial action.

Procurement Fraud

- An individual was sentenced to 41 months' incarceration, 3 years' supervised release, 300 hours' community service, restitution of $329,200 to VA, and restitution of more than $3 million to victims of a mail fraud scheme. The individual previously was indicted and convicted on one count each of mail fraud, introduction of mislabeled devices into interstate commerce, and filing a false income tax return. A joint investigation by the VA OIG, FDA, FBI, and IRS disclosed the individual, purchasing director for an import/export company, purchased non-medical grade latex gloves and repackaged the gloves, falsely labeling them as medical grade. He sold more than eight million of the mislabeled gloves to a VA contractor who, in turn, sold the gloves to VA, and distributed them to 14 VAMCs nationwide.

- The owner and president of a medical supply company was charged in a 24-count indictment with mail fraud, making false statements to the Government, and bankruptcy fraud, after a joint investigation by the VA OIG, FBI, Army Criminal Investigative Division, and DCIS. The investigation disclosed the individual misrepresented her company as a Government contractor, misrepresented herself and others as being Government officials, and falsely certified that medical products she supplied were made in the U.S. Investigation disclosed the individual was awarded contracts for her company to provide medical supplies and equipment to U.S. military installations and VAMCs. To fulfill the contracts, the company had to purchase many of the supplies from outside sources. In the course of procuring some of these supplies, the individual presented herself as being a Government procurement officer, convincing vendors that they were receiving supply orders directly from the military or VAMC. She instructed the vendors to deliver the products directly to the facility, and then billed the facility for the goods, keeping the payment for herself and not reimbursing the vendors. Sentencing is pending.

- An individual who operated as president and owner of a company that contracted with VA to supply medical goods to VAMCs pleaded guilty to one count of distribution of misbranded medical devices. A VA OIG investigation disclosed the individual's company improperly labeled and promoted medical supplies as being sterile, when they actually had not been subjected to any approved sterilization process. The misbranded goods consisted primarily of gauze medical pads which were to be used by the VAMCs for the treatment of ulcers and burns. According to false promotional materials distributed by the company, the gauze pads assisted in the prevention of infection and promoted healing.

Contract Fraud

A company that had contracted with VA entered into a civil settlement for $105,000 with the U.S. Attorney's office. A VA OIG investigation disclosed the owner of the company charged VA for the alleged installation of adaptive equipment into vans sold to disabled veterans, when in fact they never installed the equipment. The company provided full cooperation during the course of the investigation and adopted self-initiated compliance measures to prevent future problems.

Fee Basis Fraud

- An individual formerly employed by VA as a doctor in a fee-basis program was sentenced to 39 months' imprisonment, 3 years' supervised release, and was ordered to pay $4.9 million in restitution after pleading guilty to six counts of defrauding health care benefit programs and one

count of criminal forfeiture. A joint investigation by the VA OIG, FBI, and DCIS disclosed that in 1981 the individual fraudulently obtained a state license to practice medicine and then presented to authorities that he was licensed and qualified to practice medicine. He continued this practice for almost 20 years. By using the false credentials he was able to defraud Medicare/Medicaid programs, state health benefits programs, and VA health care benefits programs of more than $4 million.

- A VAMC claims clerk in the fee basis program resigned from his position during the course of a VA OIG investigation into the theft of checks sent to the VAMC by fee basis contractors. Investigation disclosed the individual instructed a contractor to refund more than $5,400 to VA by making checks payable to him in care of VA. He admitted during the investigation that he deposited the checks in his girlfriend's bank account, diverting the funds for his own use.

- An individual employed as a nurse participating in VA's fee basis program was sentenced to 5 months' imprisonment, 5 months' home confinement, 2 years' probation, and was ordered to pay $34,600 restitution to VA and a $3,000 fine. The individual previously had pleaded guilty to two counts of submitting false claims to the Government. A joint investigation by the VA OIG and U.S. Postal Inspection Service disclosed the individual, who had been under contract with VA to perform skilled nursing visits to veterans in their own homes, submitted false invoices to VA for nursing visits that she did not perform.

Travel Benefits Fraud

- An individual was sentenced to 12 months' incarceration, 36 months' probation, ordered to pay a court fee of $200 and make VA restitution of $10,794 after pleading guilty to a one-count criminal complaint charging him with theft. A joint VA OIG and VA police investigation disclosed the individual fraudulently claimed round trip travel reimbursement benefits to a VAMC, claiming that he traveled more than 140 miles when, in fact, he traveled only a fraction of that distance.

- An individual was arrested on charges of falsifying vouchers to receive travel benefits to which the individual was not entitled. A joint investigation by the VA OIG and local police disclosed the individual, an outpatient at a VAMC, entered a relative's address on paperwork provided to VA, telling VA that it was the individual's own address, thereby obtaining increased travel reimbursement payments. Total loss to VA was more than $2,500 through the submission of more than 80 fraudulent travel vouchers.

- An individual was arrested based on a joint investigation by the VA OIG and local police, which disclosed the individual, a veteran outpatient at a VAMC, was receiving travel benefits to which he was not entitled. The individual provided fictitious residential addresses to VA so that he could obtain increased travel reimbursement payments. Total loss to VA was more than $27,000, through the submission of more than 650 fraudulent travel vouchers.

- An individual was indicted on felony charges of theft by taking and theft by deception, after a joint investigation by the VA OIG and local police disclosed the individual, a veteran who was an outpatient at a VAMC, received travel benefits to which he was not entitled. The individual provided fictitious residential addresses to VA so that he could obtain increased travel reimbursements in cash. The total loss to VA was in excess of $25,800 through the submission of more than 650 fraudulent travel vouchers.

- A VAMC outpatient was convicted on one count of theft of VA benefits. A joint investigation by the VA OIG and VA police disclosed the individual misrepresented his address to VA, reporting that he lived farther from the VAMC than he actually did, in order to collect travel benefits to which he was not entitled. Investigation disclosed that, over a 2-year period, the individual fraudulently collected more than $8,000 in travel benefits. He was subsequently sentenced to 5 years' supervised probation and ordered to make restitution to VA.

- An individual pleaded guilty to a criminal information in U.S. District Court charging him with theft of Government property. A joint investigation by the VA OIG and VA police disclosed the individual submitted 114 false claims for beneficiary travel expenses, indicating he resided in and traveled from a city located more than 400 miles from the VAMC when, in fact, he lived in a metropolitan area very close to the VAMC. Over the course of a 3-year period, the individual diverted more than $5,100 in travel benefits to which he was not entitled. During the course of the investigation, the individual admitted to filing the false claims and agreed to make restitution to VA.

Veterans Benefits Administration

VBA provides wide-reaching benefits to veterans and their dependents including pension and compensation payments, home loan guaranty services, and educational opportunities. Each of these benefits programs is subject to fraud by those who wish to take advantage of the system. For example, individuals submit false claims for service connected disability, third parties steal pension payments issued after the unreported death of the veteran, individuals provide false information so that veterans qualify for VA guaranteed property loans, equity skimmers dupe veterans out of their homes, and educational benefits are obtained under false representations. The Office of Investigations spends considerable resources in investigating and arresting those who defraud the benefits operations of VA.

Death Match Project

A proactive death match 2000 project was conducted by the OIG Information Technology and Data Analysis Division at the request of the Office of Investigations. The results of the match were transmitted to the investigative field offices for appropriate action. The death match identified in excess of 350 possible cases. Currently, 129 cases have been opened and 41 cases closed. These cases have resulted in the actual recovery of $783,000, with another $981,000 in expected recoveries. The five-year projected cost savings to VA is $3.5 million. In addition, there have been two arrests with several others awaiting indictment.

Employee Misconduct

Theft and Embezzlement

A VARO program support assistant was charged in a criminal complaint with misdemeanor theft. A VA OIG investigation disclosed the individual, who served as treasurer of the VA employee association located at the VARO, embezzled funds from the VA employee association fund. Investigation revealed the individual made numerous unauthorized cash and automatic teller machine withdrawals from the association's account, removing more than $1,200 which she diverted for her personal use.

Credit Card Theft

A VARO vocational rehabilitation counselor resigned and agreed to make restitution to VA.

A VA OIG investigation disclosed the individual used a Government-issued credit card to make personal purchases, including paying for a personal trip to France, concert tickets, furniture, electronic gear, and personal dental care. Additional investigation of purchases made using the card has revealed the employee may have purchased as much as $100,000 of personal goods using the Government credit card. The investigation continues and further charges are pending.

Contract Fraud

An individual pleaded guilty to converting money belonging to VA for his own use. A VA OIG investigation disclosed the individual, a pastor of a church, acted as the president of a nonprofit organization whose purpose it was to improve the quality of life for persons living in the area around the church. While acting as president, the individual applied for a $500,000 "VA Homeless Providers and Per Diem" grant, to be used to provide transitional housing and vocational skills to homeless veterans. The application was approved and VA forwarded the first $200,000 in January 1997. This was to be used for specific purposes including the purchase and rehabilitation of a building which was to become a veteran's living skills center. Investigation determined the building was never purchased and the pastor used more than $118,900 for purposes unrelated to the project.

Threats to VA Employees

A Federal grand jury indicted an individual on three counts of knowingly and willfully transmitting interstate communications containing threats to injure another person. A joint investigation by the VA OIG and USSS disclosed the individual, a veteran, made several interstate telephone calls threatening to kill an attorney appointed by VA to act as his fiduciary and guardian. He also made interstate telephone calls to a VARO during which he threatened to kill two VARO employees.

Pastor in $119,000 scam

[picture not available]

Loan Guaranty Program Fraud

Loan Origination Fraud

- A husband and wife, who contracted with a VARO to participate in the VA loan guaranty program, were each suspended for 12 months from participation in the program after it was found they had engaged in fraudulent practices. A joint investigation by the VA OIG and HUD OIG disclosed that the wife created fraudulent endorsements on a master certificate of reasonable value for condominium units, which increased the number of units approved for sale and the selling price of units under VA's loan guaranty program. She forged the names and signatures of two VARO employees on the documents in order to make the transaction look legitimate. The husband was general manager of the company which built and managed the condominium units and stood to benefit from the increases created by the fraudulent documents. Prosecution was declined by the Department of Justice and further administrative action by the VARO is pending.

- A joint investigation by the VA OIG, U.S. Postal Inspection Service, and HUD OIG disclosed evidence of a loan origination fraud scheme for properties with loans guaranteed by VA and HUD. A group of individuals falsified documents in order to qualify buyers for properties for which they were not qualified. Thus far, six individuals have pleaded guilty to charges of making false statements. Those who pleaded guilty include an attorney for a private mortgage company, two individuals employed by a home sales company, an individual formerly employed by a new home development company, a mortgage broker, and a real estate sales representative. Investigation disclosed the attorney's role in the scheme was to falsify VA loan applications by facilitating the payment of outstanding credit debts for potential buyers. One of the individuals employed by the home sales company produced fraudulent W-2 forms and other employment verification documents for potential buyers, and the second employee facilitated the payment of outstanding debts. The money used for payment of the debt would result in a second loan between the homebuyer and the home sales company which would not be disclosed on the mortgage application. The individual formerly employed by a new home development company submitted documents which contained false information. The former mortgage broker arranged for fake cash gifts to loan applicants who did not meet the criteria for guaranteed loans. These gifts enabled the applicant to appear to be financially capable of handling the mortgage payments. After the mortgage closing, the loan applicants had to re-pay the cash gifts with interest. The real estate sales representative assisted applicants in paying off existing loans and hiding the pay-offs from the lender by wrapping the new loan in an inflated property appraisal or gift letter. The investigation continues against additional individuals.

- French law enforcement authorities arrested two individuals when they attempted to pick up money that was wired to them by relatives in the U.S. Their arrest was the result of an indictment charging them with 14 counts of mail fraud. A joint investigation by the VA OIG and FBI disclosed the individuals were engaged in a nationwide bankruptcy fraud and equity-skimming scheme. They would attempt to delay foreclosure on VA-guaranteed home loans by taking over the loans and then filing bankruptcy under different company names. They also charged the homeowners exorbitant fees for participation in the service. In November 1999, a search warrant was executed on the residence where they were operating the scheme. Shortly thereafter, they fled the U.S. Additional charges are expected to be filed against the individuals in a pending superseding indictment.

- An individual was sentenced to 6 months' imprisonment and 3 years' probation after pleading guilty to a criminal information charging him with making a false statement to a federally insured lending institution. A joint investigation by the VA OIG and FBI disclosed the individual operated a "credit repair" business, which furnished documentation to home loan providers showing that borrower's bad credit had been cleared, when in fact, the bad credit remained unchanged. Among the individual's customers in the scam were persons applying for VA-guaranteed home loans.

- An individual was arrested and charged with making false statements and fraudulent use of a Social Security number after a joint investigation by VA OIG, HUD OIG, and FBI, disclosed the individual made false statements on a Federal mortgage loan application and falsely represented himself using another person's Social Security number. During the course of an interview subsequent to his arrest, the individual admitted making false statements to the Government and admitted that he had fraudulently used a Social Security number which did not belong to him. The investigation continues and charges are pending against other individuals involved in the fraud scheme.

Property Management Fraud

Ten individuals were charged with conspiring to commit bank fraud, loan application fraud, mail fraud, wire fraud and defrauding the Government in connection with the purchase of foreclosed properties. A joint investigation by the VA OIG and HUD disclosed the individuals unlawfully profited through the sale of real estate by submitting false information to banks, mortgage brokers, and the Government. The individuals used "straw buyers" to acquire foreclosed VA and HUD homes. The true buyers of the properties did not have sufficient income or assets to qualify for the loans and to pay the down payment and closing costs to purchase the properties.

Other Loan Guaranty Fraud

An individual was indicted on charges of making a false statement. A joint investigation by the VA OIG and the Social Security Administration (SSA) disclosed the individual falsified an application for a VA-guaranteed mortgage, providing misleading information regarding his identity, earnings, and employment in order to obtain a mortgage for which he otherwise would not have been qualified. The individual subsequently defaulted on the loan, causing a $36,300 loss to the Government.

Possession of Explosive Devices

An individual was charged with possession of explosive devices and reckless endangerment after a large amount of military-type explosives, weapons, and ammunition were discovered in his house during a routine foreclosure inspection being conducted by VA loan guaranty personnel. When the VA personnel located the weapons they immediately contacted the VA OIG and county police. Once on the scene, VA OIG personnel assisted police officials in conducting a search of the property and with subject interviews. Items found during the search included 81mm mortar rounds, ammunition for grenade launchers, parts for machine guns and mortars, and jugs of sulfuric and nitric acids. Other agencies involved in the continuing investigation include the Bureau of Alcohol, Tobacco, and Firearms; state fire marshals; Army Explosive Ordinance Division; and state police.

Beneficiary Fraud

VA Dependency and Indemnity Compensation (DIC) Benefits Fraud

- An individual was sentenced to 18 months' imprisonment, 30 months' probation, and VA restitution of more than $80,000, following a prior guilty plea to charges of theft of VA benefits. A joint investigation by the VA OIG and USSS determined the individual's wife had been receiving DIC benefits prior to their marriage, as the surviving spouse of a deceased veteran. VA regulations provide that remarriage or death terminates entitlement to DIC payments. Investigation disclosed the wife failed to notify VA upon her remarriage in 1983. The individual failed to notify VA when his wife died in 1988. Subsequent to the wife’s death, DIC benefits totaling more than $80,000 were deposited into her checking account and then withdrawn by the individual. The theft of these VA benefits was discovered in 1997, when the individual shot his present wife who had threatened to notify VA authorities that he was stealing VA benefits funds.

- An individual was indicted and charged with five counts of theft. A VA OIG investigation disclosed that for more than 6 years the individual failed to notify VA of the death of her mother, a VA beneficiary in receipt of DIC benefits. The individual allowed VA to continue to electronically deposit the funds into a bank account she had shared with her mother, allowing her access to more than $78,500 to which she was not entitled.

- An individual was charged with two counts of false statements after having been previously indicted on one count of theft of Government money. A joint investigation by the VA OIG and U.S. Postal Inspection Service disclosed the individual failed to report the death of his aunt, a VA beneficiary in receipt of DIC benefits. For more than 5 years, the individual allowed VA to send the benefits checks to the aunt’s home. According to VA regulations, benefits should terminate at the time of death. Investigation showed the individual endorsed and deposited the checks into a joint account bearing his and his aunt's names, converting more than $65,000 in benefits to his own use. At one point, he also completed a VA form requesting a replacement check, forging his deceased aunt's name to the form.

- An individual was sentenced to 8 months’ imprisonment, 36 months’ supervised probation, and ordered to pay VA restitution of more than $43,800 after pleading guilty to theft of public money. A VA OIG investigation disclosed the individual, a legitimate recipient of DIC benefits as the surviving spouse of a deceased veteran, failed to advise VA of her remarriage. She collected more than $44,000 in benefits to which she was not entitled. According to VA regulations, DIC benefits terminate upon remarriage.

- An individual was sentenced to 5 years’ probation and VA restitution of $38,500 after a VA OIG investigation disclosed that, for almost 15 years, he engaged in a scheme to steal VA DIC benefits intended for his mother, a VA beneficiary. Investigation showed the individual failed to report his mother’s death to VA and arranged for the funds to be direct-deposited into an account, which he and his mother had shared. He established a second bank account by forging his deceased mother's signature, transferred funds from the first account into this new account and proceeded to access and spend the funds.

- An individual was sentenced to 6 months’ confinement in a halfway house, 3 years’ supervised probation, and was ordered to pay restitution of $41,500 after pleading guilty to charges of forgery of VA benefits checks. A joint VA OIG and FBI investigation disclosed

the individual concealed the death of his mother, a beneficiary in receipt of DIC benefits as the surviving spouse of a deceased veteran, in order to wrongfully divert the benefits checks as they were mailed to her post office box. The individual negotiated the checks at a local bank after forging the signature of his deceased mother, thus diverting more than $40,000 in benefits for personal use.

- An individual was arrested after failing to appear in U.S. District Court to answer charges of theft of Government property, after being indicted on 16 counts of theft. A joint investigation by the VA OIG, SSA OIG, and Health and Human Services (HHS) OIG disclosed the individual failed to report to VA the death of his mother, a VA beneficiary, and continued to divert more than $31,000 in DIC and SSA benefits to which he was not entitled. Investigation disclosed the payments were being electronically deposited into a joint account that the individual shared with his mother, but the receipt of benefits should have been terminated at the time of her death. A trial date is pending.

- Three individuals who had previously been arrested and charged with conspiracy and mail fraud for taking part in a benefits theft scheme pleaded guilty and were each sentenced to 5 years' probation, 300 hours' community service, and restitution for their participation in the scheme. A joint investigation by the VA OIG, USSS, and local police disclosed the individuals had been acting as caregivers for an elderly individual, who was receiving DIC benefits as the surviving spouse of a veteran. The individuals failed to notify VA when the recipient died and continued for almost 2 years to receive, negotiate, and use benefits payments. Restitution was ordered in the amounts of $10,691 from one individual, $4,010 from the second, and $1,620 from the third.

- An individual pleaded guilty to a criminal information charging him with felony theft. He was subsequently sentenced to 30 months' probation and ordered to pay $13,532 restitution to VA. A VA OIG investigation disclosed the individual failed to notify VA in 1993 of the death of his mother, a VA beneficiary in recipient of DIC benefits. He continued for almost 6 years to divert benefits payments.

- An individual was sentenced to 3 years' probation and ordered to make restitution of more than $28,100 after pleading guilty to theft of Government funds. A VA OIG investigation disclosed the individual failed to disclose the death of her mother, a widow in receipt of DIC benefits, and continued for more than 3 years to allow the benefits payments to be electronically deposited in a joint account she had shared with her mother. She proceeded to access the funds, diverting more than $28,100 to which she was not entitled.

- An individual was sentenced to 5 years' probation, 6 months' home detention, and was ordered to pay $47,800 restitution to VA after being arrested and pleading guilty to charges of theft of Government funds. A VA OIG investigation disclosed the individual failed to report the death of her mother, who had been receiving DIC benefits as surviving spouse of a veteran and continued for more than 5 years to allow VA to electronically deposit the benefits payments into a bank account she had held jointly with her mother. Each month, the individual would use her deceased mother's teller-machine card and personal identification number to withdraw the funds deposited into the account by VA. By means of this scheme, the individual wrongfully converted more than $47,800 to her own use.

- An individual was arrested and pleaded guilty to charges of theft of Government funds and passing forged U.S. Treasury checks. A VA OIG investigation disclosed the individual failed to report to VA the death of her mother, a VA beneficiary, and continued for more than 3 years

to divert DIC benefits to which she was not entitled. During that time she assumed her mother's identity in order to intercept and negotiate DIC checks that continued to be mailed to her mother. The total loss to VA exceeded $32,000. Sentencing is pending.

- An individual pleaded guilty to a one-count criminal information charging him with fraudulently receiving more than $63,000 in DIC benefits intended for his mother, the widow of a veteran. A VA OIG investigation disclosed the individual failed to report the death of his mother in 1988 and continued for almost 10 years to allow the benefits to be electronically deposited into a joint bank account. Sentencing is pending.

- An individual was sentenced to 3 years' supervised release and restitution of $103,963 after being indicted on charges of theft of DIC benefits intended for his mother, the widow of a deceased veteran. Additionally, $14,510 was recovered from the bank where the VA benefits had been electronically deposited. A VA OIG investigation disclosed that for 8 years, the individual fraudulently diverted more than $118,000 in DIC benefits intended originally for his mother and later for his step-sister, who was designated recipient of the benefits after the mother died.

- A criminal complaint was filed in U.S. District Court charging an individual employed as a special agent for the U.S. Air Force, Office of Special Investigations, with theft of Government funds. A joint investigation determined that the individual had been receiving DIC benefits since 1977, as the surviving spouse of a deceased veteran. VA regulations provide that remarriage or death terminates entitlement to DIC payments. Investigation disclosed the individual remarried in 1998 and failed to notify VA. On a benefits questionnaire sent by a VARO, the individual provided false information regarding the remarriage. Since the remarriage in 1998, the individual diverted more than $17,700 in DIC benefits to which she was not entitled.

- An individual was sentenced to 5 years' probation and 500 hours' community service for her actions. A VA OIG investigation disclosed the individual wrongfully diverted DIC benefits checks issued to her mother, as surviving spouse of a deceased veteran. The individual failed to notify VA of her mother's death and continued for more than 3 years to receive and negotiate the benefits checks. Loss to VA exceeded $21,500. A restitution hearing is pending.

- An individual was charged in a criminal indictment filed in U.S. District Court with one count of theft of VA property. A joint investigation by the VA OIG and FBI disclosed the individual failed to notify VA of the death of her mother, the widow of a veteran in receipt of DIC benefits. This continued for 7 years and wrongfully diverted more than $86,700 in benefits intended for her mother.

Pension Benefits Fraud

- An individual was sentenced to 5 years' probation, 6 months' confinement to a halfway house, and ordered to pay VA restitution of $13,000 after pleading guilty on charges of theft of Government funds. A VA OIG investigation disclosed the individual failed to notify VA of the death of her father, a VA beneficiary in receipt of VA pension benefits. The individual accessed more than $14,000 in benefits to which she was not entitled.

- An individual was sentenced to 3 years' probation and ordered to pay VA restitution of $33,462. The individual, a veteran, previously had pleaded guilty to a criminal indictment charging him with theft of Government funds after a VA OIG investigation disclosed he had been receiving VA pension benefits based on no

reportable income while failing to report earnings his wife received from various jobs.

- An individual was sentenced to 3 years' probation and ordered to pay VA restitution of $24,800. The sentencing follows a guilty plea to charges of theft of Government money after a VA OIG investigation disclosed the individual, a veteran in receipt of VA pension based on no reportable income, failed to disclose income from various jobs and thereby received VA benefits to which he was not entitled.

- An individual was indicted and charged with theft of public monies. A VA OIG investigation disclosed the individual submitted false eligibility documents to VA, on which he failed to disclose family income, in order to receive pension benefits to which he was not entitled. Through the submission of the false documents, the individual received more than $9,700 in benefits.

- An individual pleaded guilty to one count of fraudulent acceptance of payments. A joint investigation by the VA OIG and Naval Criminal Investigative Service disclosed the individual, for more than 5 years, received VA pension benefits based on his claim of no other income. However, he was concealing the receipt of workers' compensation benefits for a work-related knee injury. Investigation showed the individual submitted forms to VA concealing the receipt of more than $57,000 in workers' compensation benefits and through this deception was able to receive more than $40,800 in pension benefits to which he was not entitled. Sentencing is pending.

- An individual was sentenced to 5 years' probation, 1,000 hours' community service, and was ordered to pay a $2,000 fine and $18,500 restitution to VA. He had previously pleaded guilty to making a false statement to fraudulently obtain VA pension benefits. A VA OIG investigation disclosed that, for more than 5 years, the individual annually submitted false VA income reports declaring that no employment income was received while actually working full-time in a personally-owned residential maid service. The actual employment income far exceeded the amount allowed by law for the individual to be eligible to receive VA pension benefits.

- An individual was arrested and indicted on charges of theft and forgery of a $19,700 U.S. Treasury check intended to provide VA pension benefits for the widow of a veteran. A joint investigation by the VA OIG, U. S. Postal Service, and local police disclosed the individual engaged in a scheme with her boyfriend to steal the check from the widow's mail. The pair then duped a local businessman into assisting them in negotiating the stolen check, using the proceeds to open personal bank accounts. Criminal charges are pending and the investigation continues.

- An individual pleaded guilty to charges of theft of Government funds and was sentenced to 5 years' probation, 6 months' home detention, and ordered to pay VA restitution of $28,400. The sentencing was the result of a VA OIG investigation which disclosed the individual, the sister of a deceased veteran, failed to report her brother's death to VA and continued for more than 3 years to forge and negotiate VA pension benefit checks that were issued to her brother.

Education Benefits Fraud

An individual pleaded guilty after being indicted on charges of using a false Social Security number, bank fraud, and theft of Government property relative to the wrongful receipt of VA educational benefits. A joint investigation by the VA OIG, FBI, SSA OIG, and local police disclosed the individual used the name, Social Security number, and identity of another individual enrolled at a university to enroll himself in a master's degree program at the

same university. Using the false information, the individual applied for and received VA educational benefits to which he otherwise would not have been entitled. The individual was a veteran, but would not have qualified for the educational benefits on his own because his grade point average did not qualify him for admission. He arranged for payment of the tuition and supplies by using VA's vocational rehabilitation program, which paid for tuition, books, and supplies and paid a monthly subsistence to the student. By engaging in this scheme, the individual defrauded VA into paying for an education to which he otherwise would not have been entitled. Loss to the Government was more than $17,000. Sentencing is pending.

Compensation Benefits Fraud

- An individual was indicted on five counts of wire fraud and one count of theft of public monies. A joint investigation by the VA OIG and FBI disclosed the individual, a veteran, made numerous misrepresentations to the VA relative to his military duties, injuries received, and traumatic events he witnessed while serving in the U.S. Marine Corps during the Vietnam War. The individual claimed these events caused him to develop post-traumatic stress disorder, for which he was rated 100 percent disabled. A separate investigation by the FBI and U.S. Secret Service into threats made against the President disclosed the individual was involved in making the threats in question, and further investigation resulted in findings of his involvement in the fraud. The individual pleaded guilty to possession of explosive devices in that separate matter and is serving a 13-year prison sentence for those charges. The current investigation into VA compensation fraud came about during plea negotiations in the separate investigation. Loss to VA as a result of the individual's false statements was more than $262,000.

Pickering

[picture not available]

- An individual was arrested and charged with negotiating forged U.S. Treasury checks and stealing Government funds after a VA OIG investigation disclosed the individual, the daughter of a deceased veteran, diverted VA compensation benefits checks that were mailed to her father's residence. VA had originally been notified of the veteran's death, and the benefits payments had ceased, but by contacting authorities she convinced them that the veteran was alive and was able to get the benefits payments started again. Once the checks were mailed to her father's residence, she diverted the checks, forged the name of the deceased veteran on the checks, and deposited them into her own account. Judicial actions are pending.

- A former VARO senior claims examiner was sentenced to 12 months' imprisonment and ordered to pay VA restitution of $40,000. An investigation disclosed the individual created records which fraudulently inflated the disability rating for a co-worker's disability compensation award and thereby enabled her to wrongfully obtain $40,000 in benefits payment from VA to which she was not otherwise entitled. Investigation further disclosed the former claims examiner endeavored to obstruct the investigation by counseling the co-worker to lie to special agents during the course of the investigation and by destroying evidence.

- An individual was indicted and charged with four counts of mail fraud and one count of theft of Government funds. A VA OIG investigation disclosed the individual devised and executed a scheme where, by means of false pretenses and representations, he gained power of attorney over the affairs of the widow of a deceased veteran. He alleged he was trying to assist the widow in overcoming difficulties she was having to obtain VA compensation benefits based on her husband's military service. In reality, he used the power of attorney to fraudulently obtain and convert to his own use more than $48,900 in VA benefits intended for the widow and the veteran's children.

- An individual was indicted and charged with one count of making false claims to the Government. A VA OIG investigation disclosed the individual applied for increased VA compensation benefits by declaring he was not employed and could not obtain future employment due to a service-related disability. However, he was employed full time. Based on his declaration of unemployability, he received more than $16,000 in benefits to which he was not entitled.

- An individual was charged with violating the conditions of his supervised release after a VA OIG investigation disclosed he had made false statements to the U.S. Probation Service while serving a sentence for a prior conviction on mail fraud and aiding and abetting. In order to qualify for a work-release program, the individual falsely certified that he was gainfully employed and not in receipt of any other income. However, investigation disclosed he was receiving VA compensation benefits at a rate of 100 percent due to his "unemployable" rating. Sentencing is pending.

- An individual pleaded guilty to one count of theft after a VA OIG investigation disclosed the individual had wrongfully engaged in a scheme to receive VA compensation benefits under two separate claim numbers. Investigation disclosed the individual initially collected more than $21,800 in benefits based on the submission of an altered military discharge document and a VA benefits application containing false information. During the time period that he was collecting these benefits, the individual had not yet been discharged from the military. Investigation further disclosed that, while receiving monthly benefits payments under the first claim, he also received more than $10,600 in VA benefits based on a second claim. Total

monetary loss is $32,825. Sentencing is pending.

Fiduciary Fraud

- The former wife of a veteran was sentenced to 2 years' probation and was ordered to pay VA restitution of $21,100 after having pleaded guilty to charges of mail fraud. A VA OIG investigation disclosed that, for more than 25 years, the individual submitted documents to VA which fraudulently reflected the veteran resided at certain addresses, requesting that his benefits checks be mailed there. Investigation disclosed, however, that only the wife resided at the addresses that were given, not the veteran. The wife opened a bank account in both names, forging the veteran's name on the account and on the benefits checks that were received, wrongfully converting the benefits monies to her own use.

- A VA fiduciary who previously had been arrested and had pleaded guilty to charges of theft of Government funds was sentenced to 3 years' probation, 6 months' home detention, and was ordered to pay VA restitution of $17,091. A VA OIG investigation disclosed that from May 1997 through January 1998, the individual, acting as fiduciary for her half-brother, a veteran in receipt of VA disability payments, stole the half-brother's disability payments that exceeded $1,900 per month. In May 1997, the veteran was convicted of felony charges and was sentenced to serve 5 years in prison. The fiduciary failed to notify VA that her half-brother was incarcerated and continued for 8 months to receive the disability payments until VA discovered the incarceration and terminated the benefits. Benefits should have been terminated after 60 days incarceration. The fiduciary wrongfully obtained approximately $17,000 as a result of this scheme. At the time of her arrest, the fiduciary was on probation for homicide.

- An individual serving as fiduciary for her minor child was sentenced to 18 months' probation, 50 hours' community service, and must pay $10,000 restitution in accordance with a pre-trial diversion program she entered into, pursuant to an indictment and arrest on charges of misappropriation by a fiduciary. A VA OIG investigation disclosed the individual, while serving as fiduciary for her minor child, converted to her own use veteran's life insurance proceeds totaling $10,000 which were intended for the benefit of the child. After being indicted, the individual withdrew as representative payee for Social Security benefits that were also being issued to the minor child. VA and the SSA designated the child's paternal aunt to take over the duties of VA fiduciary and SSA representative payee in order to oversee the child's benefits.

- An individual was sentenced to 2 months' imprisonment, 36 months' probation, a $5,000 fine, and 250 hours' community service after pleading guilty to a criminal information charging him with one count each of misappropriation by a VA fiduciary and fraudulent conversion of SSA benefits. A joint investigation by the VA OIG and SSA OIG disclosed the individual stole money from six veterans entrusted to his care, using the money for his own purposes.

- An individual was sentenced to 18 months' incarceration, 36 months' supervised release, 500 hours' community service, and was ordered to pay VA restitution of $7,896. He had earlier been convicted on six counts of theft of Government funds after a VA OIG investigation disclosed the individual, while serving as a veteran's financial guardian, diverted the veteran's VA pension benefits and personally used the funds.

- An individual was sentenced to 32 months' incarceration, 3 years' supervised release, ordered to pay $214,745 restitution to VA and the SSA, and reimburse the Government

$89,929 in fees that he earned as a fiduciary. The individual previously had pleaded guilty to a one count criminal information charging him with embezzlement after a VA OIG investigation disclosed the individual embezzled funds while acting as a fiduciary for SSA and VA beneficiaries.

- An individual was sentenced to 366 days' imprisonment, 36 months' supervised probation, and ordered to make restitution of $65,000 as the result of a criminal conviction on charges of embezzling VA benefits paid to an incompetent veteran. A VA OIG investigation disclosed the individual misused his position as fiduciary for an incompetent veteran to access funds to which he was not entitled.

Theft of Benefits

Two individuals were arrested pursuant to charges that they engaged in a conspiracy to negotiate stolen U.S. Treasury checks and possess stolen mail. The arrests resulted from a joint investigation by VA OIG, USSS, and U.S. Postal Inspection Service into the theft and negotiation of a veteran's VA compensation check of $27,711. Investigation disclosed the individuals conspired to divert a check from the veteran's mail, wrongfully negotiate the check and then split the proceeds, each depositing a share of the funds into personal bank accounts. Authorities were notified of the theft of VA benefits after the veteran failed to receive the payment and requested a duplicate check be issued. A criminal complaint previously was filed against the individuals in U.S. District Court and criminal proceedings are pending.

Other Benefits Fraud

- An individual pleaded guilty to wire fraud after a joint investigation by the VA OIG, SSA OIG, and the U.S. Postal Inspection Service disclosed the individual, a veteran, knowingly engaged in a scheme to wrongfully receive Social Security disability insurance benefits as well as workers' compensation benefits at the same time. According to regulations, he was not allowed to receive benefits under both programs. Investigation disclosed the individual obtained different Social Security numbers and used different names in order to obtain multiple benefits payments. Sentencing is pending.

- An individual who formerly served as national service officer for the Disabled American Veterans pleaded guilty to a criminal information charging him with soliciting and receiving funds from a veteran. A VA OIG investigation disclosed the individual solicited and received $500 as payment from a veteran who sought his assistance in applying for VA disability benefits.

Work-Study Program Fraud

- Two individuals were indicted and charged with conspiracy to submit false claims to the Government. A VA OIG investigation disclosed that one of the individuals, a VA work-study program participant at the Congressional Medal of Honor Society, submitted biweekly claims for salary payments during a period of almost a year when she did not work at the Society. She was aided in the scheme by the second individual, her sister, who was employed as a secretary by Society. The sister, in her capacity as secretary, intercepted contracts and claims forms issued by VA and furnished them to the first individual who completed and returned them to VA via U.S. mail. Loss to the Government was approximately $5,100. A trial date has not yet been set.

- Three individuals, two former VA employees and one current VA employee, were arrested and charged in three criminal informations with knowingly and willfully making materially false statements on work-study time records maintained by VA. A joint investigation by the VA OIG and FBI disclosed

that work-study time records filed for the summer and fall semesters of 1999 falsely claimed that one of the subjects was still enrolled as a student at a university when he already had graduated. Investigation further disclosed that neither the first individual nor the second, allegedly a co-worker, performed any duties for VA when they were filing the false time records. The third individual, a veterans service representative whose duty it was to supervise the work-study students, approved the false work-study time records and transmitted the information for payment.

- An individual was sentenced to 3 years' probation and ordered to make VA restitution of $3,800 and to undergo counseling after pleading guilty to two counts of fraud and two counts of forgery. The sentencing was the result of a joint investigation by the VA OIG and state police which disclosed the individual, a veteran participating in a VA-sponsored work-study program, forged her supervisor's initials and filed at least 12 fraudulent time sheets, falsely claiming that she worked more than 400 hours.

Credit Card Fraud

An individual was charged in a criminal information with one count of theft and one count of credit card fraud, after a joint investigation by the VA OIG, VA police, and local authorities disclosed the individual stole a VA credit card from a VA employee's wallet while visiting the employee's home. The individual used the card to purchase more than $3,300 in merchandise for personal use, including purchasing custom wheels and special tires for his automobile. Surveillance was conducted on the employee's home and an adjacent parking lot during the course of the investigation, in order to gain information that may have led to the identification of the individual who stole the card. During the surveillance, a vehicle was observed parked with wheels and tires identical to the ones purchased with the stolen card. A records check of the license plates indicated that it was owned by a relative of the VA employee, who admitted during a subsequent interview to stealing the card. The relative further admitted to each transaction as it appeared on the card statement. Further judicial action is pending.

Board of Veterans' Appeals

Employee Misconduct

An individual employed as an attorney with the Board of Veterans' Appeals was suspended for 30 calendar days after being charged with unauthorized use of a Government computer and harassment. A VA OIG investigation disclosed the individual used her Government computer to access an Internet e-mail provider to create a fictitious account, which she then used to send threatening and harassing e-mail messages to two co-workers.

Office of Human Resources and Administration

Support to VA Central Office

An individual formerly employed as a contract security guard assigned to VA was arrested and charged with the theft of $3,700 in Government property. A joint investigation by the VA OIG, Federal Protective Service, FBI, and VA police disclosed the individual and two associates were involved in a series of thefts of computers and computer-related equipment from VA offices. The individual and his associates were observed removing equipment from VA offices and concealing it for pickup at a later time. One of

the associates has already been charged in the case; the other associate still has charges pending. The total loss was nearly $100,000.

National Cemetery Administration

Employee Integrity

A former assistant director of operations at a VA national cemetery was convicted on five counts of converting Government property to his own personal use or the use of others, and one count of mail fraud. A VA OIG investigation disclosed the individual initiated the illegal removal of 400,000 tons of soil from the cemetery where he worked. In an effort to justify the illegal removal of soil, he prepared a false service contract in an attempt to validate the operation. The contractor with whom he made the fraudulent arrangement made over $17,000 in profit from the operation. The individual has been on leave without pay since he was indicted. The chief operating officer for the company that removed the soil pleaded guilty in a separate hearing in U.S. District Court to one count of obstruction of justice.

OIG Forensic Document Laboratory

The OIG operates a nationwide forensic document laboratory service for fraud detection that can be used by all elements of the VA. The types of requests routinely submitted to the laboratory include handwriting analysis, typewriting analysis, ink and paper analysis, analysis of photocopied documents, and suspected alterations of official documents.

There were a total of 40 reports issued during this semiannual period.

Laboratory Cases for the Period	
Requester	Cases Completed
OIG Office of Investigations	17
VA Regional Offices	20
Office of Security and Law Enforcement	1
Other Federal Agency	2
TOTAL	**40**

The following are examples of completed laboratory work:

- Laboratory examinations during this period identified fraudulent documents in two cases submitted by VARO Manila that prevented payment of $87,505 in VA benefits.

- The laboratory identified forged signatures and fraudulent documents in seven Government life insurance cases that prevented payment of $79,082 to the wrong beneficiaries.

- The U.S. Small Business Administration OIG submitted two requests for handwriting analysis. Two top executives of a company were charged with receiving $3.2 million in progress payments from the Government on construction contracts. Subsequently, they did not pay subcontractors $1.2 million for work they certified had been completed. Both executives were charged with conspiracy to defraud, false claims, and major fraud against the Government. Laboratory analysis identified the executives as the authors of handwriting on the fraudulent documents and checks submitted by the executives. One of the executives pleaded guilty and the other is awaiting trial.

- A former VAMC physician was the subject of a major VA OIG investigation to determine

whether he intentionally murdered VA patients under his care at a VAMC. The laboratory was called upon for assistance several times during this high profile investigation. Handwriting and medical document analysis was conducted, as well as coordination with the FBI laboratory, regarding the analysis of hair samples taken from the doctor's deceased girlfriend. The role of the laboratory supported an indictment of the doctor and his guilty plea to, among other charges, three counts of murder.

- The VA loan guaranty service requested laboratory examinations of power of attorney and real estate loan documents to determine if the signatures were genuine. Laboratory examinations determined the documents were forged and identified a law enforcement officer as the author of the documents. The case was sent for further investigation.

- VA OIG investigated an individual who assisted the widow of a 100-percent service connected veteran in obtaining DIC benefits. The widow did not understand English. Laboratory examinations identified that the individual forged the widow's signature on U.S. Treasury checks as well as on 41 other documents. The subject was responsible for defrauding the widow of $48,915. During the trial, the defense agreed with the laboratory findings, which played a major role in the jury finding the defendant guilty on four counts of mail fraud and one count of theft.

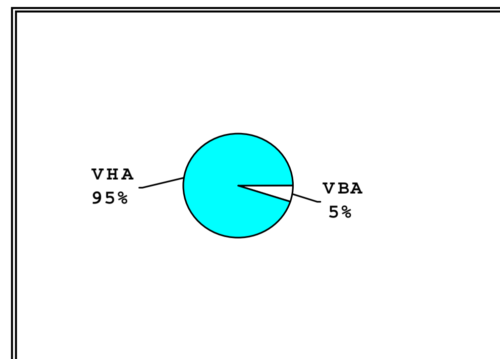
II. ADMINISTRATIVE INVESTIGATIONS DIVISION

Mission Statement

> ***Independently review allegations and conduct administrative investigations generally concerning high ranking senior officials and other high profile matters of interest to the Congress and the Department.***

Resources

The Administrative Investigations Division has nine FTE assigned. The following chart shows the percentage of resources utilized in reviewing allegations by program area.



Overall Performance

During the reporting period, the Division closed 22 cases, 2 of which had Congressional interest.

Output

- During the reporting period, eight reports were issued. Fourteen cases resulted in administrative closures.

Outcome

- Administrative sanctions: VA managers agreed to take 11 administrative sanctions against high-ranking officials.
- Corrective actions: VA managers agreed to take seven corrective actions to improve operations and activities, to include issuing bills of collection in three instances for collection of monies due VA.

The Administrative Investigations Division reports discussed below address serious issues of misconduct against high-ranking officials and other high profile matters of interest.

Veterans Health Administration

Travel Reimbursement Issue

An administrative investigation substantiated that a VAMC Director, while detailed to another facility, routinely claimed and was reimbursed daily lodging expenses that were above the maximum rate allowed by the General Services Administration. As a result, the Director improperly received $495. VHA officials agreed with our recommendation to take appropriate administrative action against the Director and issue him a bill of collection. Officials also agreed to take appropriate administrative action against another senior official who approved the expenses and against a third employee who knowingly disregarded established per diem rates requesting actual expenses without proper justification. *(Travel Reimbursement Issue, Central Alabama Veterans Health Care System, 99-01455-54, 4/3/00)*

Sale and Consumption of Alcohol Issue

An administrative investigation substantiated that a VAMC Director violated Federal regulations and state law by not giving written approval for the consumption of alcohol during a fundraising event on the facility's grounds and by not obtaining a state license for the sale of the alcohol. VHA officials agreed to our recommendations to take appropriate administrative action against the Director and to advise him to fully inform regional counsel of the circumstances when assessing the appropriateness of selling alcohol on-station. *(Improper Approval for the Sale and Consumption of Alcohol, Carl T. Hayden VAMC, Phoenix, AZ, 99-01793-102, 8/4/00)*

Conflict of Interest Issue

An administrative investigation substantiated that a VISN Director created an improper conflicting financial interest by participating in an official capacity (in her former position as a VAMC Director) in negotiations with a corporation on whose board of directors she served. The negotiations resulted in VA granting a license to the corporation to use real property, rent free, at the medical center. VHA officials agreed to our recommendation to take appropriate administrative action against the Director and to review the appropriateness of the license granted. *(Conflict of Interest and Other Issues, VA Great Lakes Health Care System, Hines, IL, 99-00875-50, 5/11/00)*

Quarters Issues

An administrative investigation substantiated that a VAMC Director claimed reimbursement for extensions to his temporary quarters authority, without adequate justification. We concluded the Director provided no compelling reason beyond his control to remain in

temporary quarters longer than 60 days, as required, and therefore received $2,886 in excessive reimbursements. VHA officials did not agree that the Director's extensions were unjustified, stating that his commitment to his work at the medical center precluded him from finding permanent housing in a more timely manner. VHA officials therefore did not concur with our recommendation that the Director reimburse the Government. Although we continue to believe the Director made decisions within his control regarding his house-hunting efforts, we withdrew the recommendation. Our investigation also substantiated that the Director and Associate Director improperly converted clinical space to temporary quarters for the Director, using VA resources. Further, we substantiated that the Director and Chief of Facilities Management did not ensure that the Director paid the full value of the furniture and services he received while in temporary quarters. VHA officials agreed with our recommendations that appropriate administrative action be taken against the officials involved in these improprieties. They also agreed to issue a bill of collection to the Director for additional furniture rental fees. *(Employee Quarters and Other Issues, VAMC Houston, TX, 99-01208-124, 9/27/00)*

Veterans Benefits Administration

Misuse of Appropriated Funds

An administrative investigation substantiated that senior VARO officials, including the Director, improperly used appropriated funds to purchase meals and refreshments on four occasions over a 5-month period. The food was purchased for VA and non-VA individuals attending a variety of meetings and a reception. VBA officials agreed to our recommendations to take appropriate administrative action against the officials and to ensure that they are provided training on the proper use of appropriated funds for the purchase of meals and refreshments. *(Use of Appropriated Funds for Meals and Refreshments, VBA Regional Office, Seattle, WA, 00-00894-121, 9/26/00)*

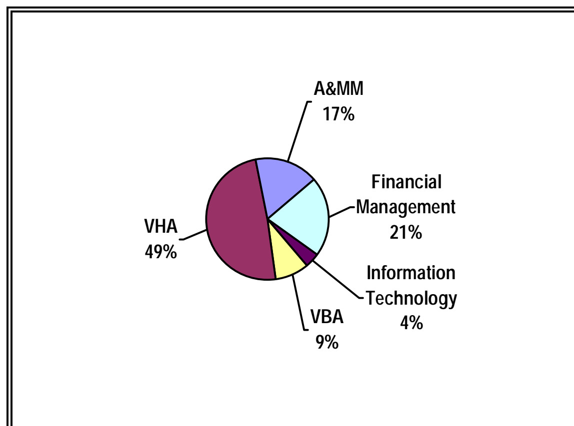
OFFICE OF AUDIT

Mission Statement

Improve the management of VA programs and activities by providing our customers with timely, balanced, credible, and independent financial and performance audits and evaluations that address the economy, efficiency, and effectiveness of VA operations, and that identify constructive solutions and opportunities for improvement, and to conduct preaward and postaward reviews to assist contracting officers in price negotiations and to ensure reasonableness of contract prices.

Resources

The Office of Audit had an average 144 FTE assigned in VA Central Office and 10 operating divisions throughout the country during the 6-month period covered by this report. The following chart shows the allocation of resources utilized in auditing each of VA's major program areas.



In addition, the Office of Audit's Contract Review and Evaluation Division had 24 FTE authorized for reimbursement under an agreement with the VA Office of Acquisition and Materiel Management. This Division conducts preaward and postaward reviews of certain categories of VA contracts.

Overall Performance

Output

- We issued 33 performance, financial, and CAP audits, evaluations, and reviews, for an output efficiency of 1 report per 4 FTE during this 6-month period. Additionally, we issued 24 contract review reports (12 preaward contract reviews and 12 postaward reviews), for an output efficiency of about 2.5 reports per FTE for the 6-month period.

Outcome

- We made recommendations to enhance operations and correct operating deficiencies with monetary benefits totaling $32.8 million. In addition, contract reviews identified monetary benefits associated with preaward and postaward contract reviews of $7.8 million.

Cost Effectiveness

- We achieved a return of $3 in monetary benefits for every dollar spent in performance and financial audits and evaluations during this 6-month period. We also achieved a return of $8 in monetary benefits for every dollar spent on contract reviews. Additionally, contracting officers sustained 74 percent of our recommended better use of funds during negotiations.

Customer Satisfaction

- Customer satisfaction with performance and financial audits and evaluations was 4.2 on a scale of 5, for reports issued during the period. The average customer satisfaction rating for contract reviews was 4.7 out of a possible 5.

Audits completed during the period identified opportunities to improve services to veterans,

and identified savings that could be used to increase service. The following summarizes some of the audits completed during the reporting period organized by VA component: VHA, VBA, Office of Management, and issues requiring action by multiple offices. This is followed by an assessment of the validity and integrity of the data used to evaluate GPRA performance.

Veterans Health Administration

Resource Utilization

Issue: Pharmaceutical supply inventories.
Conclusion: VAMCs could further reduce inventories by effectively using modern techniques and automated inventory management controls.
Impact: Better use of $31 million.

We performed an audit to evaluate how effectively VAMCs managed their pharmaceutical inventories. This was the third in a series of audits to assess VA inventory management practices for various categories of supplies. In FY 1999, VAMC pharmaceutical purchases totaled $951 million. At any given time during FY 1999, the value of VAMCs' inventories was about $41 million. As a result of the successful transition to a pharmaceutical prime vendor distribution program over the past several years, VAMCs have substantially reduced their pharmacy inventories from levels previously maintained under VA's centralized depot system.

However, inventories still exceeded current operating needs for many pharmaceutical items. Our audit at four VAMCs with combined pharmaceutical inventories valued at $1.7 million found that about $820,000 (48 percent) was excess. The excess inventories occurred because VAMCs relied on informal inventory methods and cushions of excess stock as a substitute for more structured inventory management. Inventory managers had not consistently or systematically determined their current inventory requirements based on item demand, safety requirements, and replenishment cycles.

To address the inventory issues, we recommended that VHA: (a) require VAMCs to establish goals for reducing inventories and to use automation for managing their inventories, (b) monitor progress in reducing inventories, (c) provide VAMC staff training aimed at improving inventory management, and (d) discourage the practice of using year-end funds to purchase unnecessarily large quantities of pharmaceuticals. We estimated that better management could reduce VAMC pharmaceutical inventories by $25 million which is a potential inventory reduction of 59 percent. Additionally, $6 million could be freed up by eliminating unnecessary year-end spending. The Under Secretary for Health concurred with the audit findings and recommendations and provided acceptable implementation plans. *(Audit of VAMC Management of Pharmaceutical Inventories, 99-00186-86, 6/30/00)*

"OIG's assistance in helping us to prioritize inventory management improvement opportunities throughout the system is very much appreciated, and we look forward to ongoing sharing of action progress."

Under Secretary for Health

Issue: Fee basis claim payments are appropriate.
Conclusion: The fee program was operating satisfactorily. Some improvements related to separation of duties, insurance billings, authorization, and coding and pricing will help avoid overpayments.
Impact: Better use of funds.

We performed the following four audits as part of a national audit of fee basis claim payments. The fee basis program enables eligible veterans to obtain health care at VA expense from non-VA providers. The purpose of the audits was to determine whether fee payments for outpatient and inpatient medical care were appropriate. Specifically, the audit objectives were to determine whether: veterans receiving fee care were eligible, amounts paid for fee care were appropriate, and fee care was the best alternative for providing medical services. We also evaluated whether third party billings were made when appropriate.

Alaska VA Health Care System and Regional Office, Anchorage

Overall, the fee basis program was operating satisfactorily. Veterans who received fee care were eligible. In FY 1998, fee payments by the Alaska VA Health Care System totaled $26 million. While some payment errors occurred due to authorization, coding, and pricing issues; these errors were not material when compared to the size of the program. Alternatives to fee care had been and continue to be explored to help reduce costs.

Areas in need of improvement included insurance billings, authorizations, coding, and payment for fee care. Based on our sample results, we estimated that FY 1998 billing and payment efficiencies totaling $476,000 could have been achieved. The Director agreed with the findings and agreed to take corrective action. *(Audit of Fee Basis Claims Payments, Alaska VA Health Care System and Regional Office, Anchorage, AK, 99-00180-53, 4/3/00)*

VAMC Long Beach

Overall, the fee basis program was operating satisfactorily. Veterans who received fee care were eligible. In FY 1998, fee payments at VAMC Long Beach totaled $2 million. While some payment errors occurred due to pricing issues; these errors were not material when compared to the size of the program. Alternatives to fee care had been and continue to be explored to help reduce costs.

Areas in need of improvement included third party billings, authorizations, coding, and pricing for fee care. Based on our sample results, we estimated FY 1998 billing and payment efficiencies totaling $154,000 could have been achieved. The Director agreed with the findings and to take corrective action. *(Audit of Fee Basis Claims Payments, VAMC Long Beach CA, 99-00180-85, 6/7/00)*

South Texas Veterans Healthcare System, Audie L. Murphy Division, San Antonio

Overall, the fee basis program was operating satisfactorily and veterans who received fee care were eligible. In FY 1998, fee payments at the Audie L. Murphy Division totaled $5 million. Fee basis program management was very knowledgeable about Federal, state, and local laws that were relative to fee basis claims and had streamlined workload processes and controls. Some payment errors occurred due to authorization and pricing issues; however, these were not material when compared to the size of the program. Alternatives to fee care had been considered for high-cost/high-use services. Areas in need of improvement included: veterans placed in state centers under warrant (a legal process for family or friends to commit potentially dangerous psychiatric patients for

evaluation and care), appropriateness of admissions and length of stay, and coding of fee care. Based on our sample results, we estimated that FY 1998 payments totaling $73,000 could have been avoided. The Director agreed with the findings and agreed to take corrective action. *(Audit of Fee Basis Claims Payments, South Texas Veterans Healthcare System, Audie L. Murphy Division, San Antonio, TX, 99-00180-91, 6/28/00)*

VAMC Little Rock

Overall, the fee basis program was operating satisfactorily. Veterans who received fee care were eligible. In FY 1998, fee payments at VAMC Little Rock totaled $6 million. Some payment errors occurred due to authorization, coding, and pricing issues; however, these were not material when compared to the size of the program. Alternatives to fee care had been implemented to help reduce costs.

Areas in need of improvement included separation of duties, authorizations, coding, and pricing for fee care. Based on our sample results, we estimated that FY 1998 payments totaling $316,000 were not properly documented or could have been avoided. The Director agreed with the findings and agreed to take corrective action. *(Audit of Fee Basis Claims Payments, VAMC Little Rock, AR, 99-00180-92, 6/28/00)*

Issue: Mismanagement of the equipment program at VAMC Decatur.
Conclusion: The equipment program was mismanaged, ADP equipment could not be located, and new computers and monitors were in storage.
Impact: Better use of funds.

We conducted the evaluation to determine the validity of allegations that: (a) logistics service mismanaged the equipment program, (b) past inventories of automated data processing (ADP) equipment identified missing items valued at hundreds of thousands of dollars, and (c) falsified information was provided to the OIG during the FY 1997 consolidated financial statement audit.

We substantiated the allegation that the equipment program was mismanaged, and partially substantiated the allegation that hundreds of thousands of dollars worth of ADP equipment could not be located during past inventories. New computers and monitors valued at over $336,000 were in storage, but were excess to facility needs; the inventory, excess/turn-in, and reports of survey programs were severely backlogged; controls over the loan-out program were inadequate to safeguard VA property; and the facility could not locate equipment with a total acquisition cost of $460,000. This occurred because the facility purchased ADP equipment based on availability of funds, rather than from a formalized plan; the equipment program was centralized to logistics service without sufficient resources to meet the workload requirements; and equipment had previously been disposed of without preparing the required paperwork to remove the items from the inventory database. We did not substantiate the allegation that falsified information was provided to the OIG during the FY 1997 consolidated financial statement audit.

We recommended that the medical center develop a formal, written plan to acquire ADP equipment based on need; ensure that new unused computers and monitors were put to use or excessed to another VA facility; and that responsibility for equipment accountability be decentralized to the using services to ensure greater control over facility equipment. The Director provided acceptable implementation plans. *(Allegations of Mismanagement of the Equipment Program at VAMC ((Atlanta)) Decatur, GA 98-00160-57, 4/5/00)*

Fraud Detection

Issue: High-risk areas in VHA's Workers' Compensation Program (WCP).
Conclusion: Costs can be reduced with enhanced management and oversight of claims in certain high-risk areas.
Impact: Reduction in program costs.

The purpose of the review was to identify opportunities for VISN 4 (VA Stars and Stripes Network) to enhance oversight, review, and implement cost containment measures to reduce costs associated with WCP claims. The VISN 4 Director requested assistance from the OIG to improve WCP management in the Network. We provided training on case management, identification of potential WCP fraud, and implementation of the OIG WCP protocol package and handbook. In addition, we reviewed selected claims and assisted Network facility WCP Coordinators/Specialists in identifying required case management actions.

The review found the Network had initiated actions to improve management. However, additional effort was needed to strengthen case management to assure the appropriateness of some claims. Based on the review results, we identified opportunities for the Network to reduce annual costs by about $2.9 million, with an estimated lifetime benefit cost reduction of over $37.9 million. The review also identified 10 claims that were potentially fraudulent. The review results were provided for the Network Director's use and information. *(Management Advisory Letter: Workers' Compensation Program Assist-VISN 4, 99-00046-116, 9/25/00)*

Veterans Benefits Administration

Fraud Detection

Issue: Implications of employee thefts from the Compensation and Pension (C&P) program, and internal control vulnerabilities.
Conclusion: VBA needs to improve internal controls in the C&P program.
Impact: Assuring program integrity.

The Under Secretary for Benefits asked the OIG to help identify internal control weaknesses that might facilitate or contribute to fraud in VBA's C&P program. The request followed the discovery that three VBA employees had embezzled nearly $1.3 million by exploiting internal control weaknesses in the C&P benefit program. As a follow up to our June 17, 1999, vulnerability assessment, *Management Implications of Employee Thefts from the C&P System, and Observed Internal Control Vulnerabilities*, we audited internal controls for C&P benefits at VARO St. Petersburg, FL. We selected VARO St. Petersburg for follow up audit because it is one of the largest VAROs, accounting for 6 percent of C&P workload, and it was the location where 2 of the 3 known embezzlements took place. The objectives of the audit were to determine whether internal control vulnerabilities existed that may facilitate fraud or claims examination error, and to probe for potential on-going fraud that may have escaped detection by VA and VARO controls.

We confirmed that 16 of 18 categories of vulnerability reported in our vulnerability assessment were present at VARO St. Petersburg. Two vulnerabilities identified in our June 1999 vulnerability assessment were not present at VARO St. Petersburg: the issuance of multiple employee Benefit Delivery Network

command authorities that would allow them to both adjudicate and authorize the same claim, and employee accountability issues associated with non-traditional organizational models. We also performed a series of tests to identify potentially fraudulent C&P benefit payments, including a review of over 1,000 benefit awards that evidenced potential fraud indicators. As a result of our tests, 64 cases were referred to the OIG Office of Investigations for further investigation and 72 cases were referred to VARO St. Petersburg for administrative review.

We made 15 recommendations to strengthen internal controls for the C&P program over such areas as the physical and electronic security for sensitive files; access, controls, and security over the Benefit Delivery Network; and employee conflict of interest. The Under Secretary for Benefits concurred with the findings and recommendations in the report. *(Audit of the C&P Program's Internal Controls at VARO St. Petersburg, FL, 99-00169-97, 7/18/00)*

Office of Management

VA's Consolidated Financial Statements (CFS)

Issue: Public Law 104-208, Federal Financial Management Improvement Act (FFMIA) of 1996.
Conclusion: Correction of noncompliance items is in-process.
Impact: Improved stewardship of VA assets and resources.

Our Report on Compliance with Laws and Regulations included in our report on the Audit of VA's FY 1999 CFS discussed the Department's noncompliance with FFMIA (Public Law 104-208) requirements concerning housing credit assistance program financial management information systems, information system security, and cost accounting standards.

Correction of noncompliance items is in process. VA has taken a number of steps to establish a comprehensive information system security program and established a target date of FY 2003 for completing corrective actions concerning Department-wide information system security weaknesses. The Department reported to us that they have completed correction of the housing credit assistance program financial management information system noncompliant issues. Previously reported target dates for completing implementation of systems to fully comply with managerial cost accounting requirements changed from FY 1999 to FY 2000 for NCA, and FY 2000 to FY 2001 for VHA.

We are in the process of testing and evaluating the actions as part of our audit of VA's FY 2000 CFS.

Issue: Financial management.
Conclusion: Management letters were issued to assist the Department in improving financial management.
Impact: Improved financial reporting and control.

As part of the CFS audit, we issued eight management letters addressing financial reporting and control issues. The letters provided Department managers additional observations and advice that will enable the Department to improve accounting operations and controls. These issues included: VBA benefit programs; property, plant, and equipment; payroll; medical facility receivables; and ADP security.

None of the conditions noted had a material effect on the FY 1999 CFS, but correction of the conditions was considered necessary for effective operations. Where needed, appropriate

adjustments were made to the financial statements. *[(i) Management Letter: FY 1999 Financial Statements, VA Life Insurance Programs and Selected Loan Guaranty Program Financial Activities 1999-00002-60, 4/21/00;*
(ii) Management Letter: Accuracy of FY 1999 Property, Plant, and Equipment Financial Information, 1999-00001-75, 6/1/00;
(iii) Management Letter: Accuracy of Department of Veterans Affairs' Payroll Data for FY 1999, 1999-00008-76, 6/1/00;
(iv) Management Letter: Medical Facility Receivables, 1999-00008-77, 6/1/00;
(v) Management Letter: ADP Security at Veterans Affairs Stars and Stripes Healthcare Network, 1999-00003-81, 7/1/00;
(vi) Management Letter: ADP Security at VHA, 1999-00003-83, 7/1/00;
(vii) Management Letter: ADP Security at Veterans Affairs Pittsburgh Healthcare System, 1999-00003-74-7/1/00; and
(viii) Management Letter: FY 1999 Consolidated Financial Statement Audit - Benefits Programs, 1999-00005-99, 7/14/00]

Issue: Management of accounts receivable.
Conclusion: Progress was made in improving the effectiveness of accounts receivable management.
Impact: Enhanced revenues.

The purpose of this evaluation was to determine the effectiveness of VHA's accounts receivable management, the appropriateness of medical care collection fund debt write-offs and adjustments, and to identify opportunities to enhance collections. We found that management has generally made progress in improving the effectiveness of accounts receivable management. This included pursuing collection of delinquent third-party accounts with insurance carriers, contractually adjusting accounts receivable balances, and documenting accounts receivable write-offs. We identified three areas needing management attention: improved timeliness of billing insurance carriers, follow up of first party accounts receivable, and enhanced collection efforts for employee and vendor debts. The Director agreed with the findings and initiated corrective action. As a result, we made no formal recommendations. *(Evaluation of Accounts Receivable Management, VAMC Washington, DC, 1999-00155-0066, 4/3/00)*

Preaward Contract Reviews

Issue: Federal Supply Schedule vendors' best prices.
Conclusion: Contractors can offer better prices to VA.
Impact: Potential better use of $595,674.

Preaward reviews of offers from three wheelchair manufacturers' resulted in potential savings of $595,674.

Issue: Nuclear imaging equipment vendors' best prices.
Conclusion: Vendors can offer better prices to VA.
Impact: Potential better use of $2,770,990.

Preaward reviews of three direct delivery nuclear imaging equipment vendors resulted in potential savings of $2,770,990.

Issue: Health care resource contracts.
Conclusion: VA can negotiate reduced contract costs.
Impact: Potential better use of $499,210.

We completed reviews of four proposals for scarce medical specialists' services wherein we concluded that the contracting officer should negotiate reductions of $499,210 to the proposed contract costs.

Postaward Contract Reviews

Issue: Contractor overcharges for pharmaceuticals and medical supplies.
Conclusion: Postaward audits and surveys disclosed overcharges.
Impact: Recovery of $3,225,642.

- We completed six Public Law 102-585 compliance reviews at pharmaceutical companies. For five of the six companies, we discovered errors in the calculation of Federal Ceiling Prices that resulted in contract overcharges. The five companies agreed to pay $2,561,588 to VA. We also made recommendations to all of the companies reviewed suggesting ways they could improve their policies and procedures so that the Government and the company could be assured that its systems were producing accurate Federal Ceiling Prices.

- We completed three reviews of subsistence prime vendors. Monetary findings amounted to $464,054. We have recommended that the contracting officer issue a bill of collection for the amount due.

- A pharmaceutical company agreed to pay $200,000 related to pricing disclosures that were not accurate, complete, and current during negotiations leading to a Federal Supply Schedule contract with VA.

Issue: Contract with medical/surgical prime vendor.
Conclusion: VA overpaid on medical/surgical supplies.
Impact: Potential recovery of $612,475.

A VA medical center's contract with a medical/surgical prime vendor was not cost-effective and many of the claimed savings such as reductions in full-time employees never materialized. As a result, the medical center overpaid $612,475 on medical/surgical supplies because the prime vendor could not deliver on promised savings and overcharged VA on several items. The contracting officer issued final decision letters to the prime vendor to recover $400,000 in guaranteed contract savings and $212,475 in contract overcharges. Those decisions have been appealed by the prime vendor to the VA Board of Contract Appeals.

Multiple Office Action

Security Controls

Issue: Security controls for VA systems.
Conclusion: Security controls need to be strengthened to ensure that VA systems are adequately protected.
Impact: Improved ADP controls.

As part of our audit of VA's FY 1999 consolidated financial statements, the OIG contracted with an independent public accounting firm to conduct penetration tests of selected VA systems. OIG staff assisted in the testing. The review identified a number of significant control weaknesses, and provided several high-level recommendations as well as additional specific findings and measures for enhancing security of the systems tested. The Under Secretary for Benefits and the Principal Deputy Assistant Secretary for Information and Technology provided responsive comments. *(Final Report - Department of Veterans Affairs Penetration Review, 99-00003-83, 7/1/00)*

Implementation of GPRA within VA

The OIG has a significant role to play in informing both VA and Congress on issues concerning efforts to implement GPRA. As background for our efforts in this area, it is relevant to note that VA was an OMB-designated pilot agency for performance measurement. As such, VA began establishing performance measures for its programs and operations in FY 1992.

In FY 1998, at the request of the Assistant Secretary of Planning and Analysis, we initiated a multi-stage audit to examine the integrity of the data used for GPRA reports. This ongoing project involves a series of audits to evaluate the validity, reliability, and integrity of the data used to evaluate GPRA performance.

Current Status

As part of our ongoing assessment to validate the accuracy and reliability of VA's performance measures in accordance with GPRA, the OIG is auditing two VHA performance measures and one VBA performance measure. These measures are:

VHA Performance Measures: Prevention index and addiction severity index.

VBA Performance Measure: Foreclosure avoidance through servicing.

We will issue reports on each performance measure as audits are completed. GPRA related audit reports issued to date include:

Review of Implementation of VHA's Strategic Plan and Performance Measurements, 5R1-A19-026, 2/6/95.

Review of Implementation of NCS's Strategic Plan and Performance Measurements, 5R1-B18-082, 7/6/95.

Review of Implementation of VBA's Strategic Plan and Performance Measurements, 5R1-B18-100, 8/25/95.

Audit of Data Integrity for Veterans Claims Processing Performance Measures Used for Reports Required by the GPRA, 8R5-B01-147, 9/22/98.

Accuracy of Data Used to Measure Claims Processing Timeliness, 9R5-B01-005, 10/15/98.

Accuracy of Data Used to Measure Percent of Veterans with a Burial Option, 9R5-B04-103, 5/12/99.

Accuracy of Data Used to Count the Number of Unique Patients, 9R5-A19-161, 9/20/99.

OFFICE OF HEALTHCARE INSPECTIONS

Mission Statement

Promote the principles of continuous quality improvement to provide effective inspections, oversight, and consultation to enhance and strengthen the quality of VA's health care programs for the well being of veteran patients.

Resources

The Office of Healthcare Inspections (OHI) has 34 FTE assigned to staff headquarters and field operations. OHI inspectors commit all of their staff time to healthcare inspections and evaluation issues. CAPs occupy approximately 75 percent of OHI resources.

Overall Performance

Output

- We published nine final reports during the reporting period.
- We published findings in 14 CAP reports during the reporting period.
- We evaluated responses for 82 Hotline cases to ensure the Department adequately responded to allegations of poor patient care and management.
- We conducted oversight evaluations on 12 Office of the Medical Inspector projects.

Outcome

- We made 32 recommendations, focused on improving both clinical care delivery management efficiency, and holding responsible staffs accountable for their actions.
- We followed up on 11 Department responses to Hotline allegations because not all of the issues appeared to be satisfactorily resolved. Some of these cases are described further in the Hotline Division part of this report.

Customer Satisfaction

- Program managers' satisfaction and acceptance level of our work was an average of 4.8 on a 5.0 scale for the year.

Veterans Health Administration

Nationwide Health Care Program Review

Issue: VHA's long-term care patient discharge planning.
Conclusion: Interdisciplinary treatment/discharge planning teams use appropriate caution before discharging long-term care patients.
Impact: Improved access and efficiency of long-term care resources.

This review was initiated after several veterans service organizations questioned the appropriateness of VHA clinicians discharging long-term VA nursing home care unit (NHCU) patients to community-based facilities. This followed the 1998 report of the Federal Advisory Committee on the future of VA long-term care.

We concentrated our review on those facilities which regularly discharged patients who had occupied a NHCU bed for more than 730 days. We found that clinicians did not consider patients for discharge unless they were medically and psychologically stable and could be transferred to a more appropriate level of care. Interdisciplinary treatment/discharge planning teams used appropriate caution before deciding to discharge long-term patients. In addition, clinicians effectively used the availability of community resources to facilitate outplacement in community-based settings. VA

clinicians placed patients in state veterans home programs, community residential care programs, and contract nursing home programs. In addition, respite care programs were available in most of the VAMCs. These programs permit patients being cared for by family or friends in their homes to be admitted for up to 30 days, giving the caregivers short breaks from providing care.

Patients' families do receive due-process information about their appeal rights if they disagree with a decision to discharge patients to the community. At present, this is being done at the time of admission to the VA NHCU. We suggested that this be done at the time of discharge as well. We also suggested the expansion of the use of respite care programs. This would assist caregivers and help in returning patients to home environments after a period of nursing home care. *(Focused Review of VHA's Long-Term Patient Discharge Planning, 98-00449-89, 06/29/00)*

Healthcare Inspections

Issue: Emergency treatment for critically ill patient.
Conclusion: Patient transfer procedures were flawed.
Impact: Strengthened patient transfer policy.

We conducted an inspection at the request of a member of Congress, who received allegations from a complainant concerning the quality of care provided at the medical center. We reviewed the medical care provided to a patient before his death and the pending transfer of the patient for emergent procedures. We reviewed allegations that the VAMC lacked transfer policies, and or inappropriate actions led to the patient's death.

We did not substantiate these allegations. We concluded that the VA transfer policies in place at the time of the incident did not contribute to the patient's death. We found that clinicians acted properly to treat the patient and stabilize him before transfer. The medical record indicated that the patient's rapid deterioration would have resulted in death despite transfer. We did find the lapse between the time the physician wrote the order for transfer to arrival of the transportation appeared excessive and that documentation of patient transfers could be improved. The Director concurred with the recommendations. *(Inspection of Alleged Untimely Patient Transfer, Jerry L. Pettis Memorial VAMC, Loma Linda, CA, 00-00847-62, 05/11/00)*

Issue: Inadequate operating room management.
Conclusion: Managers recognized and corrected most of the problems.
Impact: Improved operating room environment.

Two complainants alleged that VA clinicians provided improper care to two patients and mismanaged certain medical center operations. We did not substantiate that a patient who presented himself for treatment at the outpatient clinic received improper care. We also did not substantiate that surgeons had to amputate a patient's leg because clinicians improperly positioned him on an operating room table during an earlier surgical procedure. We substantiated an allegation that the medical center's operating rooms were unsanitary. However, a new nurse supervisor corrected the condition before our visit.

We did not substantiate that a supervisor and a subordinate employee were involved in a personal relationship. However, there was a long-standing perception among employees that the subordinate employee received preferential treatment, which kept the service in constant turmoil. The medical center Director concurred with our recommendations and implemented

appropriate actions to resolve the issues. The supervisor has stepped down from the position, and the subordinate employee has left the VAMC for employment elsewhere. We are continuing to follow up on recruitment efforts to resolve staffing issues in the section until the issue is resolved. *(Patient Care and Management Issues at Overton Brooks VAMC, Shreveport, LA, 99-01432-78, 06/14/00)*

Issue: Adequacy of care provided to woman veteran.
Conclusion: Improved communication and timely responses to consult requests.
Impact: Strengthened outpatient consultation services.

A complainant alleged that she did not receive adequate care while hospitalized at the VA medical center, and that the VA would not reimburse her for medical care sought at a non-VA hospital. We did not substantiate allegations of inadequate medical care. However, we identified control weaknesses in processing the patient's consults and requests for home nursing care. We found that the medical care the patient received at a non-VA medical facility did not meet VA criteria for reimbursement.

The medical center Director concurred with our recommendations to strengthen the VAMC's consultation process. VAMC employees are currently automating this process, which should improve controls. The Director acted to dedicate one individual to conduct discharge planning and work closer with agencies providing post-discharge care in response to our remaining recommendation. (*Patient Care Issue at VAMC Omaha, NE, 00-00025-95, 08/04/2000)*

Issue: Suicide on medical center grounds.
Conclusion: Clinicians treated the patient properly, but patient safety measures were not always followed.
Impact: Strengthened patient safety procedures.

We reviewed allegations that a patient committed suicide because VAMC employees had not properly managed his care and that the availability of unsecured weapons on VA property provided for an unsafe environment. We reviewed the dosages and combinations of medications the patient was taking, medical records, and related documentation, and conducted interviews with applicable employees. We could not confirm that the patient received improper care.

We substantiated the patient was able to obtain a weapon from the private quarters of a former employee who was living on VA grounds. The patient used the weapon to commit suicide on the VAMC campus. We concluded that VAMC managers did not ensure employees in VA quarters properly registered and secured their firearms on station grounds as required by VAMC policy. Administrative action against the responsible officials and the former employee who owned the weapon could not be taken because they no longer work for the Government.

The new Director agreed to take administrative action against one VA employee still working at the VAMC, who knew of the unregistered and unsecured weapons and did not act or report the policy violation. *(Patient Care Management Issue at the Carl Vinson Department of Veterans Affairs Medical Center, Dublin, GA, 00-01019-110, 08/23/00)*

Issue: The adequacy of treatment provided to a neurological patient.
Conclusion: Emergency room waiting times were excessive.
Impact: Facilitated improved admission times for patients needing hospital care.

We reviewed allegations that a patient received deficient care and treatment at the VAMC. Managers reviewed similar complaints received from the same complainant and initiated their own internal review. VAMC managers did not substantiate seven of eight allegations made by the patient's family. They did find there was a delay in the patient receiving prescribed feeding supplements. The Director took appropriate corrective actions to prevent similar delays and compensated the family for expenses that they incurred in obtaining an interim supply of the feeding supplement.

In our oversight role, we reviewed the remaining seven allegations and disagreed with VAMC internal reviews on other issues. We disagreed with VAMC managers that a 10 or more hour wait in the emergency room was acceptable, and we disagreed that the patient was ever a candidate for low-level home health care. We also concluded that better documentation of the patient's care could have enhanced the effectiveness of the patient's case management. We made four recommendations and the Director concurred and provided implementation plans for corrective actions. *(Treatment Provided to a Patient at the Department of Veterans Affairs Medical Center, New Orleans, LA, 99-012411-112, 08/23/00)*

Issue: Maintenance of treatment records.
Conclusion: Improper disposal of essential diagnostic files.
Impact: Improved ability to track patients with cardiac conditions.

We received an allegation from an anonymous source that an employee destroyed cineangiocardiography films prematurely because the employee wanted more space. The employee initially admitted to destroying films that were 5 years old or older, but later stated only films 7 years and older were destroyed. Regardless of whether the films were 5 or 7 years or older, employees are required to retain cardiac catheterization films for 20 years after the last episode of patient care. Because of the potential Title 18 U.S.C. violation (destruction of Federal documents), we sought the advice of the U.S. Attorney General's office, which declined criminal prosecution in favor of administrative action.

The Director concurred with recommendations to improve controls over film retention, and conduct risk assessments on whether the loss of these films will affect patients. The Director also agreed to take administrative action against the responsible employee regarding the inappropriate destruction of Government files/records. *(Destruction of Cineangiocardiography (CINE) Films, William Jennings Bryan Dorn VAMC, Columbia, SC, 00-01202-114, 08/31/00)*

Issue: Post traumatic stress disorder program weaknesses.
Conclusion: Poor management led to dysfunctional program.
Impact: Improved treatment and enhanced patient satisfaction.

We reviewed multiple allegations from an anonymous complainant pertaining to a variety of issues at the VAMC. The complainant

provided allegations that he collected from multiple individuals, most of whom are VAMC patients. Additional individuals contacted the OIG during the course of the inspection. We interviewed VA managers, employees, and patients. We grouped the allegations, many of which had similar themes, into management, clinical care, and administrative categories.

While we did not substantiate some of the complaints, we did substantiate allegations pertaining to the overall ineffectiveness of the facility's post traumatic stress disorder program. We substantiated allegations concerning excessive delays in patient access to specialty care, and patient distrust and dissatisfaction with the patient representative program. We substantiated allegations of inadequate patient privacy and medical record confidentiality, privacy and security for female inpatients in acute psychiatry, insufficient handicapped restroom access, and inadequate access to hepatitis "C" follow up care. In addition, we identified some cases of questionable care, which required further review.

We made 16 recommendations for improving overall services. The medical center Director concurred with the recommendations and provided detailed implementation plans. *(Multiple Management and Patient Care Issues at the Department of Veterans Affairs Medical Center, Omaha, NE, 00-00025-111,* 09/05/00)

Issue: Substandard care.
Conclusion: Domiciliary patients were unable to access their primary care physicians in a timely manner.
Impact: Reduced waiting times.

We reviewed allegations that changes to the current organizational structure at the VA health care system resulted in substandard care in the domiciliary care for homeless veterans program. The complainant alleged that the organizational realignments have caused delays for patients in receiving timely primary health care appointments. The complainant also alleged that patients were receiving substandard care and that patients and employees were not safe. In addition, the complainant alleged timekeeping irregularities in the incentive therapy and compensated work therapy programs.

We substantiated that patients were not able to access their primary care providers in a timely manner, and that patients were waiting too long for new primary care appointments. In addition, we substantiated irregularities in incentive therapy timekeeping practices, but not in the compensated work therapy program. There was no conclusive evidence to support an allegation that the medical center's reorganization resulted in substandard care for patients. We did not substantiate that domiciliary patients' or employees' safety had been compromised.

We recommended that the medical center Director assess the timeliness of primary care appointments for domiciliary patients on an ongoing basis with an emphasis on reducing waiting times. The Director concurred with the recommendations and provided adequate implementation plans. *(Patient Care Issues of Homeless Domiciliary Patients, Northern Arizona VA Health Care System, Prescott, AZ, 98-01428-119, 09/18/00)*

OFFICE OF MANAGEMENT & ADMINISTRATION

Mission Statement

> ***Promote OIG organizational effectiveness and efficiency by providing reliable and timely management and administrative support, and providing products and services that promote the overall mission and goals of the OIG. Strive to ensure that all allegations communicated to the OIG are effectively monitored and resolved in a timely, efficient, and impartial manner.***

The Office of Management and Administration is a diverse organization responsible for a wide range of administrative and operational support functions. The Office includes four Divisions:

I. Hotline Division - The Division is responsible for determining action to be taken on allegations received by the OIG Hotline. The Division receives thousands of contacts annually, mostly from veterans, VA employees, and Congress. The work includes controlling and referring many cases to the Office of Investigation, Office of Audit, and Office of Healthcare Inspections or impartial VA components for investigation.

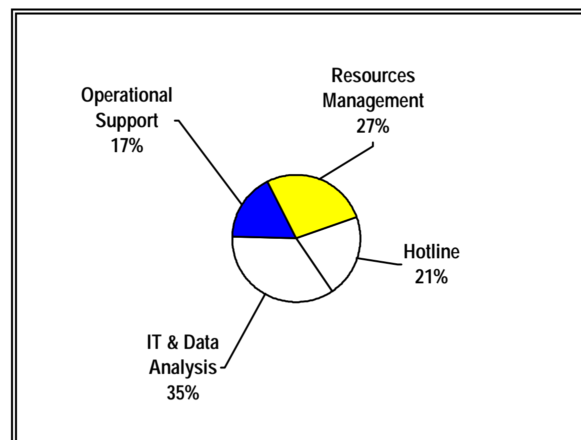
II. Operational Support Division - The Division does followup tracking of OIG report recommendations; Freedom of Information Act releases; strategic, operational, and performance planning; and IG reporting and policy development.

III. Information Technology (IT) and Data Analysis Division - The Division manages nationwide IT support, systems development and integration; represents the OIG on numerous intra- and inter-agency IT organizations; and does strategic IT planning for all OIG requirements. The Division also maintains the Master Case Index (MCI) system, the OIG's primary information system for case management and decision-making. The Data Analysis section, located in Austin, TX provides data processing support, such as computer matching and data extraction from VA databases, to the OIG and other VA entities.

IV. Resources Management Division - The Division is responsible for OIG financial operations, including budget formulation and execution, OIG personnel management, and all other OIG administrative support services.

Resources

The Office of Management and Administration has 53 FTE allocated to the following areas.



I. HOTLINE DIVISION

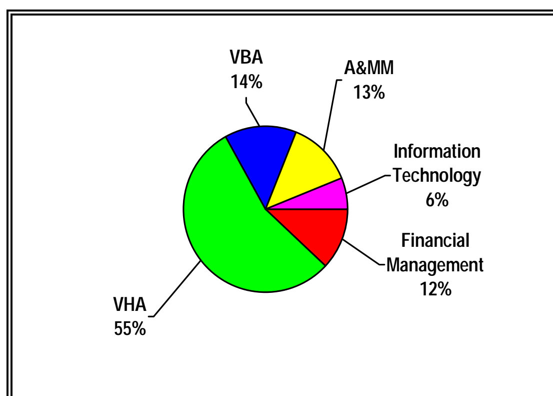
Mission Statement

Ensures that allegations of fraud, waste, abuse, and mismanagement are responded to in an efficient and effective manner.

The Division operates a toll-free telephone service five days a week, Monday through Friday, from 8:30 AM to 4 PM Eastern Time. Phone calls, letters, and e-mail messages are received from employees, veterans, the general public, Congress, General Accounting Office, and other Federal agencies reporting issues of fraud, waste, and abuse. Due consideration is given to all complaints and allegations received; mission-related issues are addressed by OIG or other Departmental staff.

Resources

The Hotline Division has 11 FTE staff positions. The following chart shows the percentage of resources devoted to various program areas.



Overall Performance

During the reporting period the Hotline received 8,319 contacts. Of this number, 547 cases were opened. The OIG reviewed 145 of these and the remaining 402 cases were referred to VA program offices for review.

Output

- During the reporting period, Hotline staff closed 461 cases, of which 204 contained substantiated allegations (44 percent). The Hotline staff opened 18 cases and generated 139 letters responding to inquiries received from members of the Senate and House of Representatives.

Outcome

- VA managers imposed 46 administrative sanctions against employees and took 75 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled $342,360.

The Hotline Division's most significant leads are referred to other OIG elements. Hotline staff also retain oversight on a number of other cases that are referred to VA program officials for resolution.

The Hotline staff worked with VA program offices on allegations concerning patient care and services, quality of care issues, employee misconduct, outside employment concerns, contracting activities, Government equipment and supplies, time and attendance, and ethical improprieties. Hotline staff also worked with VBA on allegations concerning the payment of compensation and pension to incarcerated veterans, and benefits awarded to veterans and beneficiaries who were not entitled to receive payments.

The following are some examples of Hotline-prompted reviews that were closed during this reporting period.

Veterans Health Administration

Employee Misconduct

- As the result of a Hotline inquiry, a VHA review substantiated an allegation of time and attendance abuse. The review found that two VA employees, a husband and wife, manipulated their schedules, falsified their time and leave, and covered for each other. The review also found that the supervisors failed to properly administer and monitor time and leave. As a result, management has proposed the removal of the two employees and the demotion of the service chief. Another employee will receive a written counseling.

- A VHA review substantiated the allegations of misuse of official time and inadequate staff supervision. The review found a chief consultant could not account for all of her time spent away from the medical center. As a result, VHA will establish formal procedures for the chief consultant to notify her supervisor of all absences from the medical center. Additionally, the review found that the position of director of public relations was not being well utilized. As a result, VHA will continue to review that employee's work assignments and ensure that he is fully occupied with duties commensurate with his grade level.

- A VHA review substantiated allegations of problems with administrative services and a lack of courtesy. A newly hired employee failed to provide a veteran with specific information on the cancellation of her medical examination, the medical center's toll-free number, and the purpose of the exam. Further, the employee was not courteous in dealing with the veteran. The facility is giving the new employee customer service training, access to the appointment management menu, and will improve communication with supervisory and clinical personnel concerning patient scheduling.

- A VHA review substantiated the allegation of destruction of Government documents. An employee destroyed signed equipment inventory listings, believing the forms were outdated. The employee will receive training to ensure compliance with the record keeping requirements of her position.

- A VHA review determined a VAMC motor vehicle operator was driving with a suspended license and that another motor vehicle operator at the facility was using illegal drugs. Management immediately assigned both employees to non-driving duties. The driver who was using drugs has since undergone two drug tests and faces possible termination.

- A VISN review substantiated the use of inappropriate language by a VAMC's chief of surgery. The chief of surgery was counseled that his habit of referring to female employees as 'babe' or 'sugar' would not be tolerated and would result in corrective action should he continue to use this inappropriate language.

- A VHA review substantiated an allegation that a food service employee was behaving in an angry manner, scaring at least one co-worker. The employee was given a verbal counseling, emphasizing that inappropriate behavior would not be tolerated.

- A VHA review found a pattern of serious misconduct and misconduct allegations involving a VAMC physician assistant. The VAMC conducted an administrative investigation to review the scope of practice of the physician assistant. Management decided to have a second staff member present during all of the physician assistant's examinations.

Quality of Care

- As the result of a Hotline inquiry, VAMC officials verified there are occasional problems with noise in the sleep laboratory within the psychiatric ward. It was noted, however that this placement affords a level of safety to the sleep technician, who would otherwise be isolated with patients who can be assaultive. The medical center will explore the addition of soundproofing in the sleep lab bedrooms.

- A VHA review substantiated allegations of negligence and poor communications with a patient. A patient suffered an unnecessary 5-hour delay in the emergency room (ER) awaiting a surgical consult. Further, a home health care consult was initiated for this patient by the ER physician, but was erroneously forwarded to the wrong service for initiation, causing an undue delay in initiating the patient's home health care services. The senior surgical resident received an oral counseling from the surgical service line director. The importance of reporting to the ER in a timely manner was included in the orientation for all surgical residents. The ER medical director informed staff of the proper procedure for processing future home health care consults. Additionally, surgical staff were reminded to document all patient telephone contacts in patients' medical records.

- A joint review by two VAMCs substantiated delays in diagnosis and treatment, poor communications with patient and family, and inadequate staff supervision of a veteran who was receiving care from both facilities within the VA healthcare network. The facilities implemented a corrective process and action plan to better coordinate and educate both staff and patients about intra-network transfers and coordination of care. These action plans will be monitored through the joint medical executive committee for full implementation and performance measurement.

- A VHA review substantiated the allegation of periodic low staffing levels. As a result, the facility intensified recruitment efforts, lowered the geriatric evaluation care unit census, floated staff from other areas, and adjusted daily staffing.

- A VHA review substantiated the allegation of inadequate documentation; the facility lost a veteran's dental records from 1994-95. The facility is attempting to work with the veteran by offering him continued dental services if he so wishes.

- A VHA review substantiated allegations of inappropriate treatment and poor communications with a patient. Upon the patient's check-in, a medical clerk put the medical record in the wrong clinical slot, causing a two-hour delay in the patient's appointment. Further, it was discovered that the care provider did not have complete medical test results from the referring facility. Additionally, the patient was not correctly reimbursed for travel mileage. The facility implemented procedures to assure that complete medical records are available from referring facilities before patients' scheduled appointments. The procedure for check-in and chart processing for areas where one clerk handles multiple clinics was changed. Finally, the patient was reimbursed for the correct travel mileage.

- A VHA review substantiated allegations of poor communications with patients and patient abuse by a physician. The facility found the physician's approach to the interpersonal aspects of health care to be unacceptable. The physician was stern, demanding, and uncompromising in his dealings with some patients. He received counseling and a written reprimand regarding this behavior, and further customer service training was proposed for him. The facility reports noticeable improvement in the physician's interactions with patients since administrative action was taken.

- A VHA review substantiated a patient's allegations of improper diagnosis at a VA outpatient clinic. Presenting with shortness of breath, tingling, and dizziness, the patient was given an EKG, but not a stress EKG. He was sent home and 6 days later required emergency heart bypass surgery. The clinical staff received training to recognize and manage angina pectoris that presents in an atypical way.

- A VHA review substantiated a veteran's allegation of poor communication by medical center staff, who failed to inform the veteran when his appointment was made that his eyes would have to be dilated for an examination for diabetic retinopathy. The VAMC Director apologized in writing for the miscommunication and later telephoned the veteran.

- A VHA review substantiated allegations of poor communications with a patient and a delay in the patient's receipt of a satisfactory prosthesis. Although the contractor involved made a serious effort to satisfy the veteran, additional delays in his securing a satisfactory prosthesis resulted from poor follow up communications between the veteran and the VA prosthetics and sensory aid representative. The facility has since referred the veteran to another contractor and has counseled the prosthetics representative on the expected quality of customer service.

- A VHA review substantiated allegations of poor discharge planning by a VAMC. The VAMC staff made the veteran obtain his own transportation home following his early morning emergency room discharge. The review also found that a social worker was on duty, but was never notified of the veteran's situation. The nurse supervisor reviewed proper discharge planning with the staff.

- A VHA review at a VAMC substantiated allegations of inappropriate and incorrect treatment by a pharmacist, who failed to consult the prescribing physician before changing a patient's medication. Further, the physician wrote an insufficient prescription to adequately cover the number of tablets needed for the dosage prescribed. Pharmacy staff failed to follow established procedures to ensure the prescribed number of tablets would cover the dosage. The prescription was rewritten, pharmacy staff counseled, and an admonishment issued to the pharmacist.

- A VAMC investigation substantiated an allegation that proper security measures were not observed as a patient was admitted to the hospital. This failure left the patient's belongings vulnerable. Nursing staff was reminded of hospital policy regarding proper procedures to secure patients' belongings.

- A VHA review substantiated an allegation of poor communication with a patient by a physician. The physician failed to notify a patient about his cancer test results and available methods of treatment. The breakdown in communication resulted in an effort to hire a nurse case-manager to coordinate the care of patients with complex cases across clinics.

- A VHA review substantiated allegations that a veteran did not receive timely medical treatment, that a doctor was insensitive to the patient's needs, and that communication with the patient and family was poor. Management counseled the staff members involved and issued an apology to the patient and his wife. Corrective action included recruiting additional practitioners for the clinic.

- A VHA review substantiated the allegation of poor communication with a patient by a VA employee. Both the veteran and the employee conceded that they should have handled the situation in a more professional manner. The employee's supervisor counseled her about the matter.

- A VHA review substantiated the allegation of a backlog of patients waiting for outpatient care services at a VAMC. Numerous specialty and primary care clinics were found to have waiting times greater than the VHA standard of 30 days. Recommendations included consultation with other VAMCs and an aggressive approach in addressing the backlog.

Fiscal Controls

- As the result of a Hotline inquiry, a VAMC review found that a veteran was erroneously billed for his Agent Orange examination. The facility issued a credit to the veteran.

- A VAMC review substantiated an allegation of mismanagement of resources. An insurance company made several requests over a 3-year period for a refund of overpayment for care provided to a veteran. The VAMC issued a $47,564 refund to the company.

- An Office of Financial Policy review substantiated the allegation of negligence by a VAMC. The medical center made a coding error on an employee's court-ordered child support deduction, resulting in an under-deduction of more than $100 per pay period. The correct method for computing court-ordered deductions was addressed in a national conference call to payroll offices.

Outside Income

Prompted by a Hotline inquiry, a VHA review substantiated violations of ethical conduct standards. A physician was paid a $500 stipend by a drug company representative to observe a surgical procedure at a VAMC. The physician received a reprimand and was ordered to return the $500. Additionally, the VAMC notified the company of the unethical conduct of its representative. The review also revealed that an employee stole a magazine from a patient and was caught trying to mail it to a relative using a franked Government envelope. Since the employee was previously caught stealing food from the canteen, management terminated the employee.

Patient Safety

- Prompted by a Hotline inquiry, a VISN review substantiated a violation of patient safety. The reviewers found that during a period of extremely hot weather, senior management failed to properly supervise the coordination of services during the shutdown of air conditioning in the nursing home care unit, which placed the patients' safety at risk. The facility has since conducted an analysis to develop a structured system for documenting communication and coordination of services in unusual events.

- A VHA review substantiated the allegation of an environmental safety hazard at a VA outpatient clinic. Although an independent engineering firm found no immediate structural danger in an overhead walkway, the report recommended that repairs be accomplished as soon as possible.

Government Equipment and Supplies

- Prompted by a Hotline inquiry, a Health Eligibility Center review substantiated the allegation of problems with automated data processing services. A particular veteran's health enrollment record was identified as one of those affected by a previously reported software problem. The veteran's record was corrected. The Center staff has initiated several database clean-up projects to improve the quality and integrity of data being transmitted between VAMCs and the Center.

- A VHA inquiry substantiated an allegation of misuse of a VA e-mail account by an employee. The employee who initiated the message was counseled. The recipient, a

supervisory employee not in the direct line of work with the sender, was also counseled.

- A VHA review substantiated the allegation that the chief of engineering service used a VA wire locating system for personal use at his home for over a month. As a result, the service chief received an admonishment and new procedures for the use and accountability of all equipment were enacted.

- A VHA review substantiated the allegation of misuse of Government resources by a retired dental technician. The retired employee was allowed to use dental lab equipment to make a crown for his wife. The chief, dental service has since reviewed the proper use of VA resources and equipment with all dental staff.

- A review by a VAMC substantiated the allegation that major equipment in the radiology department was allowed to sit idle without being declared surplus. The equipment in question was taken out of service and will be dismantled and removed. Officials will receive training for identifying equipment that should be relinquished, and the number of inventory spot checks will be increased.

Contracting Activity

- Prompted by a Hotline inquiry, a VHA review substantiated the allegation of contract/procurement irregularities. A contract was awarded without full justification and documentation, and the local contracting officer failed to request needed additional justification prior to initiating contracting action. VAMC management is analyzing the facility's contracting processes to prevent recurrence.

- A VAMC review at a state veterans home found significant non-compliance with VA standards. In an individual veteran's case, the review found the veteran's medical chart was improperly documented by his attending physician, which caused an unnecessary delay in his treatment. Based on these findings, VAMC management recommended the Secretary of Veterans Affairs stop VA payments to the nursing home and domiciliary. The Secretary agreed with the recommendation and payments were stopped.

- A VHA review substantiated an allegation of misuse of official time by a VA-contracted emergency room physician. While scheduled to be on duty in the emergency room, he was conducting compensation and pension examinations, for which he billed VA separately. The physician was counseled about his actions and agreed to reimburse the VA for 43 illegally billed examinations. The estimated recovery for the VA was $3,060.

- A VHA review substantiated the allegation of inappropriate treatment by a fee-basis care provider. The physician over-extended the doctor/patient relationship by making personal loans to the patient. Additionally, the provider billed the veteran for a co-payment. VAMC management discussed the inappropriate relationship with the provider and advised her that third party billing is strictly prohibited under the fee-basis program. The veteran is now under the care of another provider.

Personnel Issues

Prompted by a Hotline inquiry, a VISN review found conflict of interest and the appearance of preferential treatment towards an employee by a VAMC's associate director. VHA took appropriate administrative action against the associate director.

Ethical Improprieties

- Prompted by a Hotline inquiry, a VHA review substantiated the allegation of violation of ethical conduct by a consolidated mail-out pharmacy supervisor, and found evidence that

some medications (inhalers) were missing. The supervisor, who was also the facility contracting officer technical representative, was found to be in violation of a contract. Further, this supervisor was found to have threatened two VA employees and one contract employee with termination. The medical center director counseled this supervisor regarding proper contracting regulations and personnel management issues. Staff members were warned concerning the missing medications.

- A VHA review substantiated the allegation that a nursing supervisor accepted gifts from staff. Although it appeared that these gifts were given on a voluntary basis, several of them violated 5 CFR § 2635, which sets limits on the value of gifts given from an employee to their supervisor. The regulations have been reviewed and distributed to staff, and the facility has included an overview of these regulations in its new employee orientation agenda. This matter was referred to the Office of General Counsel for further action.

Abuse of Authority

Prompted by a Hotline inquiry, a VAMC review substantiated an allegation of abuse of authority. The police section chief abused his authority when he took 4 days of annual leave, while he had a cancellation of annual leave in effect for his staff. The police chief was counseled.

Workers' Compensation

- As the result of a Hotline inquiry, a VHA review showed that, although the paperwork on an employee's workers' compensation claim was properly completed by the VA, there is no evidence to confirm it was ever mailed to the Department of Labor. The medical center has amended its claims-handling procedures to require a notation indicating that case documentation was mailed and to follow up with the Department of Labor when a timely response is not received.

- A VAMC investigation substantiated allegations that a VA employee delayed the processing and filing of a workers' compensation claim. The employee was counseled on the proper and timely processing of such claims.

Veterans Benefits Administration

Receipt of VA Benefits

- As the result of a Hotline inquiry, a VARO found that a veteran received benefits for a child who was not attending school. The VARO took action to remove the award for the child, creating an overpayment of $1,577.

- A VARO review found compensation benefits of $6,321 were withheld from a veteran's back benefits for payment of attorney fees. It was found that a check should have been issued to the veteran, not the attorney. The VARO issued the check to the veteran.

- A VARO review substantiated an allegation that a $10 late payment fee was assessed by a veteran's utility company when his guardian erroneously entered a $300 payment as $30. The guardian paid the late fee from his personal funds.

- A VBA review substantiated allegations of lengthy delays in processing applications for purchase of repossessed homes at a VARO. A realty specialist was detailed from another VARO to process the backlog, and the other VARO will continue to provide assistance, as needed.

Benefits Payments to Incarcerated Veterans

- As the result of a Hotline inquiry, a VARO review confirmed the incarceration of a veteran in receipt of pension benefits. The VARO suspended the veteran's benefits for a 3-month period, resulting in VA savings of $2,250.

- A VBA review substantiated an allegation of mismanagement of resources by a VARO for failing to reduce an incarcerated veteran's benefits award. Although the VARO initially examined the complaint, a review of the file failed to show any VARO action to obtain further information until the Hotline inquired about the situation. The estimated VA recovery was $19,220.

- A VARO review substantiated the allegation that a veteran continued to receive full compensation benefits while incarcerated. The veteran's benefits were reduced, resulting in VA savings of $13,066 over the length of his incarceration.

- A VARO review confirmed that a veteran incarcerated in a New York state prison since 1983 never reported his status to the VA. The veteran's pension will be terminated. The potential overpayment is $169,306.

- A VBA review substantiated the allegation that a veteran incarcerated in a Washington state prison since 1997 never reported his status to the VA. The regional office reduced the veteran's compensation benefits and created an overpayment of $66,905.

Privacy Issues

Prompted by a Hotline inquiry, a VBA review substantiated allegations of privacy act violations, and other violations of ethical conduct standards. The review found that correspondence meant for one veteran was inadvertently sent to another veteran. Closer scrutiny will be given to preparation of mailings to avoid future errors. In addition, a VARO employee was discourteous when the veteran called to report the mailing errors. Action was taken to provide representatives with routine customer service training.

National Cemetery Administration

As the result of a Hotline inquiry, a National Cemetery Administration review substantiated the allegation that permanent gravesite floral containers were removed from a veteran's grave at a national cemetery. Most national cemeteries have not allowed permanent floral containers in new sections for many years, since mowers or other cemetery equipment can easily damage these containers. The facility offered to replace the containers with new ones; however, the family member declined the offer.

Board of Veterans' Appeals

As a result of a Hotline inquiry, a review by the Board of Veterans' Appeals (BVA) substantiated the allegation of a violation of the Privacy Act. The BVA identified 12 documents in the compilations of 1999 and 2000 decisions of the Board that were not decisions and should not have been made available to the public. The Board determined that inadequate instructions were provided to personnel responsible for the deletion of these documents prior to publication of the decisions. Management counseled the staff responsible for the release of the protected information. The Board revised its processes for identifying and releasing decisions to the public and reviewed the new processes in a recent

training session with BVA attorneys and Board members. Further, the BVA has recalled CD-ROMs distributed to VAROs, veterans' service organizations, the Government Printing Office, and the Library of Congress.

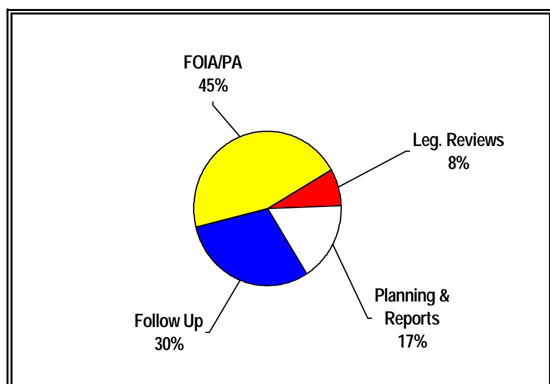
II. OPERATIONAL SUPPORT DIVISION

Mission Statement

Promote OIG organizational effectiveness and efficiency by providing reliable and timely follow up reporting and tracking on OIG recommendations; responding to Freedom of Information Act (FOIA)/Privacy Act (PA) requests; conducting policy review and development; strategic, operational, and performance planning; and overseeing Inspector General reporting requirements.

Resources

This Division has 9 FTE assigned with the following allocation:



Overall Performance

Follow Up on OIG Reports

The Division is responsible for obtaining implementation actions on previously issued audits, inspections, and reviews with over $946 million of actual or potential monetary benefits as of September 30, 2000. Of this amount $857 million is resolved, but not yet realized as VA officials have agreed to implement the recommendations, but have not yet done so. In addition, $89 million relates to unresolved reviews awaiting contract resolution by VA contracting officers.

The Division is also responsible for maintaining the centralized, follow up system that provides for oversight, monitoring, and tracking of all OIG recommendations through both resolution and implementation. Resolution and implementation actions are monitored to ensure that disagreements between OIG and VA management are resolved as promptly as possible and that corrective actions are implemented as agreed upon by VA management officials. VA's Deputy Secretary, as the Department's audit resolution official, resolves any disagreements about recommendations.

As of September 30, 2000, VA had 76 open internal OIG reports with 230 resolved but unimplemented recommendations and 25 unresolved contract review recommendations which are awaiting contracting officers' decisions.

After obtaining information that showed management officials had fully implemented corrective actions, the Division took action to close 67 internal reports and 279 recommendations with a monetary benefit of $65 million.

During this period, 100 percent of follow up requests on immediate actions were sent within

three months. Also, 100 percent of the initial and the subsequent follow up letters were processed in less than 3 months. In both cases, we met the standard.

Freedom of Information Act, Privacy Act, and Other Disclosure Activities

The Division processes all OIG FOIA and Privacy Act requests from Congress (on behalf of constituents), veterans, veterans service organizations, VA employees, news media, law firms, contractors, complainants, general public, and subjects/witnesses of inquiries and investigations. In addition, the Division processes official requests for information and documents from other Federal Departments and agencies, such as the Office of Special Counsel, the Department of Justice, and the FBI. These requests require the review and possible redacting of OIG Hotline, healthcare inspection, criminal and administrative investigation, contract audit, and internal audit reports and files. We also process OIG reports and documents to assist VA management in establishing evidence files used to support administrative or disciplinary actions against VA employees.

During this reporting period, we processed 165 requests under the Freedom of Information and Privacy Acts and released 280 audit, investigative, and other OIG reports. In one instance we had no records. Information was partially withheld in 105 requests because release would have constituted an unwarranted invasion of personal privacy, interfered with enforcement proceedings, disclosed the identity of confidential sources, disclosed internal Department matters, or was specifically exempted from disclosure by statute.

During this period, all FOIA cases received written responses within 20 work days, as required. There are no cases pending over 1 year. Our average processing times were 170 work days for complex cases, 18 work days for less complicated requests, and 14 work days for routine matters.

The Information Technology and Data Analysis Division section reports on electronic FOIA activities.

Review and Impact of Legislation and Regulations

The Division coordinated concurrences on legislative and regulatory proposals from the Congress, OMB, and the Department that relate to VA programs and operations. The OIG commented and made recommendations concerning the impact of the legislation and regulations on economy and efficiency in the administration of programs and operations or the prevention and detection of fraud and abuse. During this period, we reviewed 94 legislative, 48 regulatory, and 38 administrative proposals.

Status of OIG Reports Unimplemented for Over 3 Years

We require management officials to provide us with documentation showing the completion of corrective actions on OIG reports, including reporting of collection actions until the amounts due VA are either collected or written off. In turn, we conduct desk reviews of status reports submitted by management officials to assess both the adequacy and timeliness of agreed upon implementation actions. When a status report adequately documents corrective actions, the follow up staff closes the recommendation after coordination with the OIG office that wrote the report. If the actions do not implement the recommendation, we requests a status update.

The following chart lists the total number of unimplemented OIG reports and

recommendations. It also provides the total number of unimplemented reports and recommendations issued in FY 97 and earlier. We are particularly concerned about any report which was not implemented 3 years after being issued.

VA Office	Unimplemented OIG Reports and Recommendations			
	Total		FY 97 and Earlier	
	Repts	Recoms	Repts	Recoms
VHA	45	172	3	4
A&MM	16	30	0	0
VBA	11	46	2	2
HRA	2	2	0	0
NCA	1	3	0	0
I&T	1	2	0	0
Total	**76**	**255**	**5**	**6**

Office of Acquisition and Materiel Management (A&MM)
Office of Human Resources and Administration (HRA)
Office of Information and Technology (I&T)

Veterans Health Administration

Unimplemented Recommendations and Status (FY 97 and Earlier Reports)

Report: *VHA Activities for Assuring Quality Care for Veterans in Community Nursing Homes, 4R3-A28-016, 1/11/94.*
Recommendation: VHA develop standardized community nursing homes inspection procedures and criteria for approving homes for participation in the program.
Status: VHA provided a 6-page draft directive that was provided to only a few selected field sites for comment in March 2000. In August 2000, they indicated that they would have the directive in concurrence by the end of August 2000. However, this did not occur and no planned completion date was provided.
Concern: The OIG is concerned that this report, which dates back to 1994, has not yet been implemented. The final report showed that inspection procedures varied between VAMCs, appropriateness of community nursing homes inspection team makeup could be improved, and annual reinspections should be conducted more timely. These are still issues which need to be addressed to improve care of veterans.

Report: *Evaluation of VHA's Policies and Practices for Managing Violent and Potentially Violent Psychiatric Patients, 6HI-A28-038, 3/28/96*
Recommendation: VHA managers should explore network flagging systems that would ensure employees at all VAMCs are alerted when patients with histories of violence present for treatment to their medical centers.
Status: VHA provided a 2-page draft directive on transmission of information on assaultive patients in March 2000. In September 2000, VHA stated they felt it may be possible to publish the directive by the end of December.
Concern: The OIG report included recommendations that were meant to strengthen areas that may reduce that incidence of injury associated with violence in inpatient psychiatric units. The original planned completion date was October 1996. A directive provided in 1998 did not address the issue. The OIG is concerned that very little progress has been made in implementing this recommendation, which dates from 1996, while incidents of patient violence against staff and other patients continue.

Report: *Internal Controls Over the Fee-Basis Program, 7R3-A05-099, 6/20/97*
Recommendations: VHA improve the cost effectiveness of home health services by: (1) establishing guidelines for contracting for such services, and (2) providing contracting

officers with benchmark rates for determining the reasonableness of charges.
Status: VHA provided a 10-page draft directive on purchased skilled home health care and homemaker/home health aide services in July 2000, however it did not address recommendation (2). Currently, no planned completion date has been provided.
Concern: The June 1997 final report showed that contracting for home health services could save at least $1.8 million annually, however the recommendations remain unimplemented. The May 1997, comments to the draft report referred to a pilot project that would implement the recommendations. However, 1½ years later, the December 1998 status update reported that the pilot did not address these recommendations. We are concerned that the last four status updates from the program office reported either delays in planned completion dates or did not provide a planned completion date. As a result, over $5.3 million has been spent on these contracts which could have been avoided. We are also concerned that until this condition is corrected, at least $1.8 million annually is not saved.

Veterans Benefits Administration

Unimplemented Recommendations and Status (FY 97 Reports)

Report: *Review of the Causes of VBA's Compensation and Pension (C&P) Overpayments, 7R1-B01-105, 12/2/96*
Recommendation: VBA reduce C&P benefit over payments by revising due process procedures to remove the requirement that beneficiaries must inform the VA in writing of status changes that will result in a reduction of benefits.
Status: In September 2000, VBA stated a fast track regulation team, consisting of staff from the C&P Service and the General Counsel's Office of Regulations Management and Professional Staff II, has been formed to implement this recommendations to the extent that it is legal and feasible to do. They expect to complete drafting the proposed regulation by the end of October 2000.
Concern: The audit found that C&P overpayments could be reduced $4 million annually, if actions were taken to simplify communications with beneficiaries regarding their responsibility to report beneficiary status changes timely. We are concerned that very little progress has been made in implementing this recommendation during the past 3 years. As a result, approximately $12 million has been lost to C&P overpayments that could have been avoided.

Report: *Review of VBA's Procedures to Prevent Dual Compensation, 7R1-B01-089, 5/15/97*
Recommendation: VBA follow up on FYs 1993 through 1996 dual compensation cases to ensure either VBA disability payments are offset or the Department of Defense is informed of the need to offset reservist pay.
Status: The March 2000 status report stated VBA found a number of problems with the data files received from the Defense Manpower Data Center and the Center ran another FY 1999 file. VBA planned to use the FY 1999 data and conduct a test at one station. The September 2000 status report stated one VARO sent 147 waiver forms to veterans and will evaluate the results to determine if the revised file contains accurate data. VBA also sent a follow up request to four original regional test offices. When all the results are in, a decision will be made as to whether to release the remaining FY 1999 cases and the FY 1993 through 1998 drill pay cases. At that time, VBA will also be able to provide a planned completion date.
Concern: The audit's purpose was to determine if VBA's procedures ensured that disability compensation benefits of active military

reservists were properly offset from their training and drill pay. It found that 90 percent of the potential dual compensation cases reviewed did not have offsets from their military reserve pay. We are concerned that an estimated $8 million in annual dual compensation payments continue to be made each year because this recommendation has not been implemented.

III. INFORMATION TECHNOLOGY AND DATA ANALYSIS DIVISION

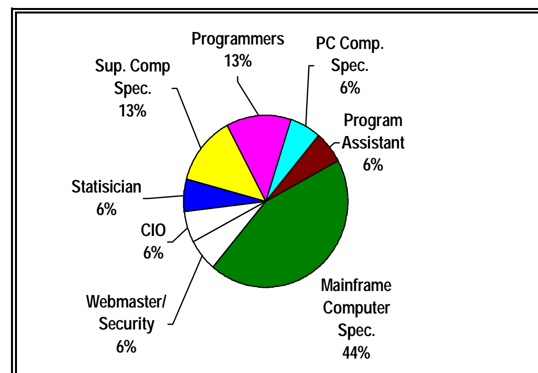
Mission Statement

> ***Promote OIG organizational effectiveness and efficiency by ensuring the accessibility, usability, and security of OIG information assets; developing, maintaining, and enhancing the enterprise database application; facilitating reliable, secure, responsive, and cost-effective access to this database, VA databases, and electronic mail by all authorized OIG employees; providing Internet document management and control; and providing statistical consultation and support to all OIG components. Provides automated data processing technical support to all elements of the OIG and other Federal Government agencies needing information from VA files.***

The Information Technology (IT) and Data Analysis Division provides IT and statistical support services to all components of the OIG. It has responsibility for the continued development and operation of the management information system known as the Master Case Index (MCI), as well as the OIG's Internet resources. The Division interfaces with VA IT units nationwide to establish and support local and wide area networks, guarantee uninterrupted access to electronic mail, service personal computers, detect and defeat computer threats, and provide support in protecting all electronic communications. The Division, which is managed by the OIG's Chief Information Officer (CIO), represents the OIG on numerous intra- and inter-agency IT organizations and is responsible for strategic IT planning for all OIG requirements. The Data Analysis section in Austin, TX provides data gathering and analysis support to those employees of the OIG, as well as the VA and other Federal agencies, requesting information contained in VA automated systems. Finally, a member of this division serves as the OIG statistician.

Resources

The Division has 18 FTE currently assigned in Washington, Austin, and Atlanta. These FTE are devoted to the following areas:



Overall Performance

Master Case Index (MCI)

During this reporting period, we completed more than 70 enhancements of the MCI, the OIG's enterprise database. Several of these enhancements were designed to streamline data entry and reduced the number of OIG keystrokes

required to complete two particular forms by several thousand a month. We redesigned the MCI forms used by auditors in order to end the duplication of effort previously devoted to periodic reporting on projects. We significantly improved the searching capability in MCI by providing users the means to bundle multiple searches into a single search.

Internet Technology/Security

The Division is responsible for processing and controlling electronic publication of OIG reports, including maintaining the OIG websites and posting OIG reports on the Internet. Data files on the OIG websites were accessed over 554,000 times by more than 116,000 visitors. Our most popular reports were downloaded over 50,000 times, providing both timely access to OIG customers and cost avoidance in the reduced number of reports that must be printed and mailed. Our vacancy announcements accounted for an additional 29,000 downloads.

We posted frequently-requested CAP, administrative investigation, and audit reports in our electronic reading room in compliance with the Electronic Freedom of Information Act. We published 18 reports, 55 Office of Investigations press releases, and other OIG publications, including this semiannual report to Congress, online.

Departmental accessibility staff checked our electronically-redacted reports which are made available online in portable document format. They informed us the reports they tested were accessible by the public including sight-impaired customers using screen reader technology. Other OIG web pages tested were accessible according to current standards.

We completed networking all OIG field offices which allows direct access to all internal VA resources without having to use outside Internet services. We implemented an OIG-managed data storage and e-mail encryption system to protect sensitive information and to enable secure communications both within and outside the OIG.

We reviewed and commented on Departmental policies and programs involving information security, accessibility, and Internet resources and utilization. Areas we addressed included policies for ensuring information posted on VA websites is not restricted, current plans for public key infrastructure deployment in the VA, and proposed security notices for VA websites.

Statistical Support

The OIG statistician is part of the technical support team under the direction of the OIG's Chief Information Officer. The OIG statistician is the subject matter expert providing statistical consultation and support to the VA OIG. The statistician provides assistance in planning, designing, and sampling for relevant IG projects. In addition, the statistician provides support in the implementation of appropriate methods to ensure that data collection, preparation, analysis, and reporting are accurate and valid.

For this period, the OIG statistician and a computer specialist provided statistical support for all CAPs. This support involved preparing and processing the random samples of full-time VAMC employees who were part of the CAP's employee satisfaction survey. In addition, the individuals provided support to process the CAP data collected while on-site.

Information Technology Training Initiative

We contracted with four vendors to provide instructor-led training in a variety of *Microsoft* applications in our newly constructed classroom in our Washington, DC headquarters office and one vendor with training facilities in each city in which the OIG is located to provide training for

our field employees. To date, 77 employees have received 125 days of instructor-led training.

As a result of a partnership with the Department of Treasury, each OIG employee also received at nominal cost a computer-based training package on two compact disks originally developed for the Internal Revenue Service. This multi-media package contains tutorials for novice, intermediate, and advanced users of *Microsoft Word, Access, Excel, PowerPoint,* and *Outlook*.

DATA ANALYSIS SECTION

This section analyzes data in VA computer files and systems. They develop proactive computer profiles that search VA computer data for patterns of inconsistent or irregular data with a high potential for fraud and refer these leads to auditors and investigators for further review. They conduct reviews that identify invalid or erroneous information in VA computer files. They provide automated data processing technical assessments and support to all elements of the OIG and other governmental agencies needing information from VA computer files.

The section completed 133 ADP support requests from VA OIG staffs during this period to include support for 19 CAP reviews. They also provided end-user support to 72 OIG staff members and offices in response to ADP questions or problems.

The support provided by the staff is reported in many of the OIG audits, inspections, and investigative cases described in other sections of this report.

Fraud Leads and Internal Controls

During this period, the section worked closely with OIG investigators, auditors, and the VA Office of Financial Policy, Financial and Systems Quality Assurance Service. Seven computer profiles designed by the section to identify potential internal and external fraud were tested at four VAROs. These profiles used patterns of fraudulent data created in the past by employees to illegally generate payments to themselves or co-conspirators. Subsequently, 30 cases of potential fraud among the 306 claim folders examined were referred to OIG investigators with potential VA recoveries of more than $1.6 million. Examples include:

- Eight potentially non-existent veterans existing on VA files were identified at a particular VARO. The computer profile was developed exclusively using VA databases. One employee at this office was discovered issuing payments in the name of a deceased veteran in care of an acquaintance of the employee. Judicial action is pending in this case. Potential VA recoveries are $340,764.

- Seventeen potentially deceased veterans still receiving VA benefits checks were identified at one VARO and were referred to OIG investigators for further review. Potential VA recoveries are $645,768.

Postaward and Preaward Contract Reviews

The section assisted OIG auditors by providing ADP support in obtaining and analyzing the sales data provided by independent vendors seeking or under contract with VA. During this reporting period, we completed 13 requests from OIG auditors reviewing post- and pre-award VA contracts. Examples include:

- The staff completed 56 ADP reports in support of an OIG review of a pharmaceutical

company under contract with VA. Working with Department of Justice staff, we copied and provided back to the company sales information the company did not have and could not reproduce. The vendor's hardware was obsolete and the data required special handling to convert the company's sales data into a medium that could be processed using VA computers.

- Most purchase of pharmaceutical products is conducted through use of a prime vendor. We were able to obtain copies of the prime vendor sales to VA that proved useful to OIG auditors in conducting post-award and pre-award reviews of VA contracts. The data helped auditors assist VA contracting officers in price negotiations and ensuring the reasonableness of contract prices.

Other Federal Agencies

The section completed 18 requests for information from other offices. Examples include:

- On several occasions, the staff provided data to the Department of Health and Human Services OIG concerning allegations of fraudulent submission of records to the Health Care Financial Administration by a variety of health care providers.

- The staff provided data to the Department of Justice regarding allegations that a manufacturer of pipes may have sold defective plumbing pipes to several Federal departments including VA. We discovered 13 sales of this pipe to VA.

- The staff provided the Department of Health and Human Services with information about a physician who surrendered his medical license in one state and moved to another. We were asked to query several databases to determine if this physician had been employed by or done business with VA. He had not.

- The staff provided the Department of Justice with information to assist their investigation of widespread fraud within Government agencies dealing with a certain company. Allegations focused on the fraudulent billing practices of a certain company and whether VA may have also been defrauded. Our research determined VA had not been victimized.

Requests from VA

During this reporting period, the section completed 31 requests for information from other VA offices. Examples include:

- As part of the section's support for the OIG audit of VA's consolidated financial statements, we routinely provide VHA with a quarterly file containing VHA's accounts receivable transactions. VHA uses this file in performing a national reconciliation of accounts receivable in all of its facilities. During a quarter, there are approximately 10 million accounts receivable bills and 20 million payment transactions.

- We provided data for the VARO Manila Director that revealed an abnormally large number of recipients one hundred years of age or older. We also identified those recipients for whom no date of birth or Social Security number was recorded. The absence of this data makes it impossible to independently identify either suspiciously old or deceased payees using computer matching.

- We assisted VBA by providing data files to be used in evaluating the capabilities of competing vendors to design software that could identify potential fraud.

IV. RESOURCES MANAGEMENT DIVISION

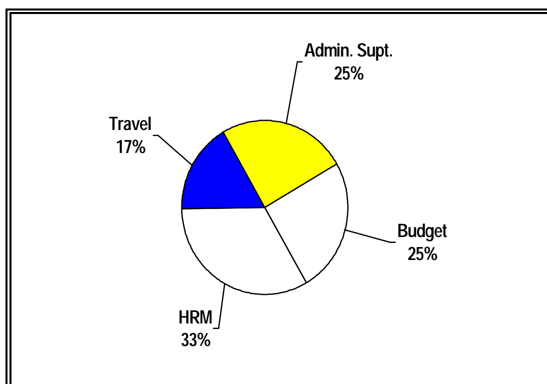
Mission Statement

> ***Promote OIG organizational effectiveness and efficiency by providing reliable and timely management and administrative support services.***

The Division provides support services for the entire OIG. Our services include personnel services and liaison; budget formulation, presentation, and execution; travel processing; procurement; space and facilities management; and general administrative support.

Resources

The Division has 14 FTE currently assigned. The staff allocation for the four functional areas is as follows:



Overall Performance

Customer Satisfaction

Customer satisfaction survey forms are randomly provided to OIG employees throughout the year. The average customer satisfaction rating was 4.3 out of a possible 5.0.

Budget

The staff executed 99.95 percent of the OIG's FY 2000 budget authority.

Human Resources Management

During this period, the staff brought 17 new employees on board. In addition, the staff processed 97 personnel actions, 1 distinguished career award, 6 outstanding career awards, 151 special contribution awards, 12 time-off awards, 30 on-the-spot awards, and 2 peer awards.

Travel

By the nature of our work, OIG personnel travel almost continuously. As a result, we processed 1,877 travel and 54 permanent change of station vouchers in addition to 10 new permanent change of station authorities and 16 amendments to existing authorities.

Administrative Support

The administrative staff works closely with central office administrative offices and building management to coordinate various administrative functions, office renovation plans, telephone installations, and the procurement of furniture and equipment.

In addition, this component processed 264 procurement actions and reviewed and approved, each month, the 44 statements received from the OIG's cardholders under the Government's purchase card program.

OTHER SIGNIFICANT OIG ACTIVITIES

President's Council on Integrity and Efficiency (PCIE)

Hotline & IT/Data Analysis Teams

[picture not available]

- Employees of the Hotline Division and the Information Technology and Data Analysis Division received a PCIE award for outstanding use of information technology (IT) tools as a means to further the effectiveness of the OIG operational elements.

Investigations, Audit, and Management and Administration Teams

[picture not available]

- Employees of the Office of Investigation, Office of Audit, and the Office of Management and Administration received a PCIE award for outstanding accomplishments in the audit and investigations of the VBA compensation and pension internal controls system. The audit and investigations resulted in improved internal controls for a claims processing system which administers over $21 billion in benefits annually.

- OIG employees also received six PCIE "honorable mention" awards.

- A manager from the Central Office Audit Operations Division was part of an IT roundtable subcommittee tasked to devise a PCIE survey of IT capabilities within the IG community. As part of the subcommittee, he helped develop the survey, test the questions, and collect the results from individual IGs.

- The OIG Webmaster made a presentation on website privacy requirements, electronic redactions, E-FOIA, and the new accessibility standards at a PCIE webmasters conference.

OIG Management Presentations

8th Annual Leadership VA Alumni Association Forum

The Inspector General spoke to VA executives and managers at the forum. His presentation was titled *"Building One IG for One VA."*

50th Anniversary of the Association of Government Accountant's Professional Development Conference

The Director, Audit Operational Support Division, made two presentations on the Office of Audit's internal quality assurance program, including internal peer reviews and self-assessments.

National Occupational Health and Safety Conference

A project manager from the Central Office Audit Operations Division teamed with representatives from VHA on a presentation outlining the joint OIG/VHA efforts to enhance VHA's workers' compensation program. The conference, held in San Antonio, had over 300 VA health and safety attendees.

VA Information Technology Conference

- The Director and a project manager from the Central Office Audit Operations Division teamed with VHA's National Safety Director in a presentation on "*Using IT for Successful Workers' Compensation Case Management and Fraud Detection*." The conference offered training on the latest case management techniques to 3,000 attendees.

- Auditors from the Central Office Audit Operations Division made a presentation on "*Utilization of 'Dump ACL' for Auditing Permissions*." The presentation highlighted the use of software that can identify vulnerabilities in system security.

Second Annual Federal Workers' Compensation Conference and Exposition

The Director and a project manager from the Central Office Audit Operations Division, and the Special Agent in Charge, Investigations Northeast Field Office, gave a presentation on "*Using Automated Analysis to Aid in Detection of Workers' Compensation Fraud*." The conference was a collaborative effort between VA and several Federal agencies and provided educational opportunities to over 1,400 attendees for managing claims under the Federal Employees' Compensation Act.

Coalition for Government Procurement Spring Conference

The Director, Contract Review and Evaluation Division, gave a presentation on the Federal Supply Schedule program. The presentation addressed what the VA OIG believed worked well and what needed improving.

VA National Acquisition Center Industry Conference

The Director and an audit manager from the Contract Review and Evaluation Division gave a presentation on the OIG contract review process. The presentation covered preaward and postaward reviews, reviews of compliance with the drug pricing provisions of the Veterans Healthcare Act (Public Law 102-585, Section 603), and voluntary disclosures by contractors.

Association of Military Surgeons of the United States

An audit manager from the Contract Review and Evaluation Division, fielded questions from industry representatives and their consultants regarding changes proposed by the VA to improve the administration of the drug pricing provisions contained in Public Law 102-585, Section 603.

Awards

Certified Fraud Examiners Awards

- Stephen Gaskell, Director, Central Office Audit Operations Division was presented with the Fraud Examiner of the Year Award by the Washington metropolitan chapter of the Certified Fraud Examiners.

- OIG auditor, Paul E. Sawyer, received the International Association of Certified Fraud Examiners "Association's Distinguished Achievement Award for 2000," at the annual

meeting of the Washington metropolitan chapter for a lifetime of commendable service to the field of fraud examination.

Athena Award

Healthcare inspector, Paula Chapman, received the Athena Award (recognition of employee demonstrating exceptional service to women veterans) from the Central Texas VA Health Care System, women veterans committee.

OIG Congressional Testimony

- In May 2000, the Inspector General testified before the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations. The testimony addressed the results of the OIG's reviews over the last several years that have focused on VA's IT system development initiatives, procurements, and capital asset acquisition practices that identified opportunities where the Department could enhance it's IT investment efforts. The testimony also focused on the OIG's review of the Department's information system security controls.

- In June 2000, the Assistant Inspector General for Healthcare Inspections submitted testimony and participated in the House Committee on Veterans' Affairs field hearings at the Northern Indiana Healthcare System, Marion, Indiana. The hearings focused on management and patient safety issues at the VA Healthcare System.

- In July 2000, the Inspector General and the Office of Healthcare Inspections submitted testimony and responded to focused questions from the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, on the measures taken by VA to ensure patients are safe at VA health care facilities.

- In September 2000, the Assistant Inspector General for Auditing testified before the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations. The hearing focused on OIG's findings concerning the Department's automated information system security program.

Obtaining Required Information or Assistance

- Sections 5(a)(5) and 6(b)(2) of the Inspector General Act of 1978 require the Inspector General to report instances where access to records or assistance requested was unreasonably refused, thus hindering the ability to conduct audits or investigations. During this 6-month period, there were no reportable instances under these sections of the Act.

- Under P.L. 95-452, the IG has authority "… to require by subpoena the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence necessary . . . ." The use of IG subpoena authority has proven valuable in our efforts, especially in cases dealing with third parties. During this reporting period, the OIG issued 33 subpoenas in conjunction with OIG investigations and audits.

APPENDIX A

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
REVIEWS BY OIG STAFF

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM REVIEWS				
00-00025-37 4/3/00	Combined Assessment Program Review, Department of Veterans Affairs Medical Center Omaha, NE			
00-00473-63 5/4/00	Combined Assessment Program Review of VA Medical Center Denver, CO	$52,524	$52,524	
00-01072-64 5/4/00	Combined Assessment Program Review of the Carl T. Hayden VA Medical Center Phoenix, AZ	$27,450	$27,450	
00-01199-72 5/25/00	Combined Assessment Program Review, VA Northern Indiana Health Care System Ft. Wayne and Marion, IN			
00-01062-84 6/5/00	Combined Assessment Program Review, VA Medical and Regional Office Center White River Junction, VT	$215,924	$215,924	
00-00933-88 6/19/00	Combined Assessment Program Review, VA Gulf Coast Veterans Health Care System Biloxi/Gulfport, MS			
00-01227-94 7/14/00	Combined Assessment Program Review of the VA Central California Health Care System Fresno, CA			
00-01223-104 8/3/00	Combined Assessment Program Review of VA New York Harbor Healthcare System	$678,382	$678,382	$29,033
00-01202-107 8/18/00	Combined Assessment Program Review William Jennings Bryan Dorn Veterans' Hospital Columbia, SC			
00-01217-105 8/18/00	Combined Assessment Program Review of VA Medical Center Portland, OR	$158,680	$158,680	
00-02003-108 8/18/00	Combined Assessment Program Review, VA Medical Center Tuscaloosa, AL	$135,869	$135,869	
00-01225-109 8/31/00	Combined Assessment Program Review of VA Medical Center Hampton, VA	$94,000	$94,000	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM REVIEWS (Cont'd)				
00-01065-117 9/8/00	Combined Assessment Program Review VA North Texas Health Care System	$33,665	$33,665	
00-01230-120 9/25/00	Combined Assessment Program Review of VA Western New York Healthcare System	$383,785	$383,785	
INTERNAL AUDITS				
99-00180-53 4/3/00	Audit of Fee Basis Claim Payments, Alaska VA Health Care System and Regional Office Anchorage, AK			
99-00180-85 6/7/00	Audit of Fee Basis Claim Payments, Department of Veterans Affairs Medical Center Long Beach, CA			
99-00180-91 6/28/00	Audit of Fee Basis Claims Payments South Texas Veterans Health Care System, Audie L. Murphy Division San Antonio, TX			
99-00180-92 6/28/00	Audit of Fee Basis Claims Payments VA Medical Center Little Rock, AR			
99-00186-86 6/30/00	Audit of VA Medical Center Management of Pharmaceutical Inventories	$30,600,000	$25,900,000*	
99-00169-97 7/18/00	Audit of the Compensation and Pension Program's Internal Controls at VA Regional Office St. Petersburg, FL			
OTHER OFFICE OF AUDIT REVIEWS				
99-00155-66 4/3/00	Evaluation of Accounts Receivable Management VAMC Washington, DC			
98-00160-57 4/5/00	Allegations of Mismanagement of the Equipment Program at VA Medical Center (Atlanta), Decatur, GA	$336,313	$0**	
99-00002-60 4/21/00	Management Letter: Fiscal Year 1999 Financial Statements, VA Life Insurance Programs and Selected Loan Guaranty Program Financial Activities			

* VHA prefers the funds associated with a 10-day inventory goal rather than a 7-day goal since that is the VHA agreed upon initial goal.

** VAMC Decatur did not agree because the equipment was needed and had been installed.

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
OTHER OFFICE OF AUDIT REVIEWS (Cont'd)				
99-00001-75 6/1/00	Management Letter: Accuracy of Fiscal Year 1999 Property, Plant, and Equipment Financial Information			
99-00008-76 6/1/00	Management Letter: Accuracy of Department of Veterans Affairs' Payroll Data for Fiscal Year 1999			
99-00008-77 6/1/00	Management Letter: Medical Facility Receivables			
99-00003-74 7/1/00	Management Letter: ADP Security at Veterans Affairs Pittsburgh Healthcare System			
99-00003-81 7/1/00	Management Letter: ADP Security at Veterans Affairs Stars and Stripes Healthcare Network			
99-00003-82 7/1/00	Management Letter: ADP Security at Veterans Health Administration			
99-00003-83 7/1/00	Report of Review: Department of Veterans Affairs Penetration Review			
99-00005-99 7/14/00	Management Letter: Fiscal Year 1999 Consolidated Financial Statement Audit – Benefits Programs			
00-01416-106 9/19/00	Management Advisory: Selected Internal Controls, VA Medical Center Fayetteville, AR			
99-00046-116 9/25/00	Management Advisory Letter: Workers' Compensation Program Assist, Veterans Integrated Service Network (VISN) 4			
CONTRACT REVIEWS *				
99-00113-55 4/4/00	Final Report – Review of VA Medical Center Albuquerque's Contract with American Medical Depot for Distribution of Medical/Surgical Supplies			$612,475
99-00137-59 4/18/00	Review of Roberts Pharmaceutical Corporation's Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Numbers V797P-5736n and V797P-5181x			$26,373

* Management estimates are not applicable to contract reviews. Cost avoidances resulting from these reviews are determined when the OIG receives the contracting officer's decision on the report recommendations.

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs

CONTRACT REVIEWS (Cont'd)

Report Number/ Issue Date	Report Title	OIG	Management	Questioned Costs
00-00258-61 4/20/00	Review of Federal Supply Schedule Proposal (Solicitation Number 797-FSS-99-0025) Getinge/Castle, Inc., Arnold, MD	$100,820		
00-00234-65 4/27/00	Final Report Review of Fujisawa Healthcare, Inc.'s Voluntary Disclosure of Pricing Violations Under Federal Supply Schedule Contract Number V797P-5238x			$200,000
00-01815-56 5/5/00	Final Report - Review of Immunex Corporation's Voluntary Disclosure Under Federal Supply Schedule Contract V797P-5280x			$2,264
00-01378-68 5/17/00	Review of Marconi Medical Systems Inc's Direct Delivery Pricing Proposal Under Solicitation No. M6-Q7-00	$823,449		
00-00797-71 5/25/00	Review of Federal Supply Schedule Proposal (Solicitation Number 797-652F-99-0004) Electric Mobility Corporation, Sewell, NJ			
00-01584-73 5/31/00	Final Report Review of Proposal Submitted by University of Pittsburgh Physicians for Anesthesiology Physician Services at the University Drive Division VA Pittsburgh Healthcare System Pittsburgh, PA	$297,833		
97-00098-80 6/1/00	Final Report Review of Abbott Laboratories Inc.'s Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Numbers V797P-5894m, V797P-5396x, V797P-5615n, and V797P-5282x			$2,034,056
98-00088-79 6/1/00	Final Report Review of Alcon Laboratories Inc.'s Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Numbers V797P-5734n and V797P-5352x			$492,008
00-00256-69 6/6/00	Reveiw of Federal Supply Schedule Proposal (Solicitation Number RFP-797-652F-99-0004) Sunrise Medical, Inc., Longmont, CO	$595,674		
98-00097-70 6/20/00	Final Report Postaward Review of VA's Subsistence Prime Vendor Contracts with Alliant Foodservice, Inc., Deerfield, IL (Contract Numbers 10-193P-1525 and 10-193P-1527 through 10-193P-1537)			$237,207

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs

CONTRACT REVIEWS (Cont'd)

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
00-01380-90 6/26/00	Final Report, Review of Nuclear Imaging Systems Proposal Submitted by ADAC Laboratories Under Solicitation No. M6-Q7-00 Milpitas, CA	$1,947,541		
99-00098-87 6/29/00	Report of Survey, Purdue Frederick's and Pharma's Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585			
00-00489-93 6/30/00	Review of Federal Supply Schedule Proposal Submitted by Krasity's Medical and Surgical Supply, Inc. Under Solicitation Number RFP-797-FSS-99-0025			
00-00264-98 7/20/00	Review of Federal Supply Schedule Proposal Submitted by Invacare Corporation, Elyria, Ohio, Under Solicitation Number 797-652F-99-0004			
00-01693-101 7/31/00	Review of Proposal Submitted by Department of Radiology Baylor College of Medicine for the Services of a Neuroradiologist, Angiographer, and General Radiologist at the VA Medical Center Houston, Texas	$179,777		
00-01719-103 8/24/00	Review of Fujisawa Healthcare, Inc.'s Voluntary Disclosure and Refund Offer Related to Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Number V797P-5238x			$6,887
99-00097-115 9/6/00	Final Report - Review of Bausch & Lomb Pharmaceutical, Inc.'s Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585 under Federal Supply Schedule Contract Numbers V797P-5495M and V797P-5279X			$4,928
00-00265-100 9/7/00	Review of Proposal for Primary Care Services at Community-Based Outpatient Clinic in Greensburg, Pennsylvania, Submitted to VA Pittsburgh Healthcare System by University of Pittsburgh Medical Center, Presbyterian, Pittsburgh, PA	$21,600		
00-01633-118 9/18/00	Postaward Review of VA's Subsistence Prime Vendor Contract with Virginia Foodservice, Inc. Contract Number 10-193P-1538			$5,841

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
00-00241-122 9/26/00	Review of Federal Supply Schedule Proposal Submitted by Alaris Medical Systems, Inc., San Diego, California Under Solicitation Number RFP 797-FSS-99-0025			
00-01379-123 9/26/00	Review of Proposal Submitted by SVA America for Nuclear Imaging Systems Under Solicitation Number M6-Q7-00 Twinsburg, OH			
00-01634-125 9/28/00	Postaward Review of VA's Subsistence Prime Vendor Contract with Springfield Foodservice Corporation Contract Number 10-193P-1526			$221,007
ADMINISTRATIVE INVESTIGATIONS				
99-01455-54 4/3/00	Administrative Investigation, Travel Reimbursement Issue, Central Alabama Veterans Health Care System			$495
99-00875-58 4/18/00	Administrative Investigation, Reprisal Issues, VA Great Lakes Health Care System Hines, IL			
99-00875-50 5/11/00	Administrative Investigation, Conflict of Interest and Other Issues, VA Great Lakes Health Care System, Hines, IL			
99-01780-67 5/26/00	Administrative Investigation, Prosthetic Service Procurement Issue, VA Medical Center Denver, CO			
00-00906-96 7/12/00	Administrative Investigation, Reimbursement for Quarters-Related Expenses, VA Medical Center Mountain Home, TN			
99-01793-102 8/4/00	Administrative Investigation, Improper Approval for the Sale and Consumption of Alcohol, Carl T. Hayden VA Medical Center Phoenix, AZ			
00-00894-121 9/26/00	Administrative Investigation, Use of Appropriated Funds for Meals and Refreshments, VBA Regional Office Seattle, WA			
99-01208-124 9/27/00	Administrative Investigation: Employee Quarters and Other Issues, VA Medical Center Houston, TX			$1,170

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
HEALTHCARE INSPECTIONS				
00-00847-62 5/11/00	Inspection of Alleged Untimely Patient Transfer, Jerry L. Pettis VA Memorial Medical Center Loma Linda, CA			
99-01432-78 6/14/00	Healthcare Inspection, Patient Care and Surgical Management Issues at Overton Brooks VA Medical Center Shreveport, LA			
98-00449-89 6/29/00	Letter Report, Focused Review of Veterans Health Administration's Long-Term Patient Discharge Planning			
00-00025-95 8/4/00	Healthcare Inspection, Patient Care Issue at the VA Medical Center Omaha, NE			
99-01411-112 8/23/00	Treatment Provided to a Patient at the Department of Veterans Affairs Medical Center New Orleans, LA			
00-01019-110 8/23/00	Patient Care Management Issue at the Carl Vinson Department of Veterans Affairs Medical Center Dublin, GA			
00-01202-114 8/31/00	Healthcare Inspection, Destruction of Cineangiocardiography (CINE) Films, William Jennings Bryan Dorn VA Medical Center Columbia, SC			
00-00025-111 9/5/00	Healthcare Inspection, Multiple Management and Patient Care Issues at the Department of Veterans Affairs Medical Center Omaha, NE			
98-01428-119 9/28/00	Healthcare Inspection, Patient Care Issues of Homeless Domiciliary Patients, Northern Arizona VA Health Care System (NAVAHCS) Prescott, AZ			
TOTAL:	**74 Reports**	**$36,683,286**	**$27,680,279**	**$3,873,744**

APPENDIX B

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
CONTRACT REVIEWS BY OTHER AGENCIES

Report Title (Report Number, Issue Date)	Funds Recommended for Better Use	Unsupported Costs
Proposal, Project No. 589-401 A/E, VAMC Kansas City, J. Christopher Gale & Co., Kansas City, MO (2000-00021-PE-0102-N02, 4/26/00)		
Claim, Project No. 609-019 Construction, VAMC Marion, Huber, Hunt & Nichols, Inc., Indianapolis, IN (2000-00021-PE-0105-N02, 5/9/00)	$95,235	
Proposal, Project No. 852-026 A/E, VA National Cemetery St. Louis, Ottolino Winters Huebner, St. Louis, MO (2000-00021-PE-0202-N02, 5/11/00)		
TOTALS: 3 Reports	**$95,235**	**$0**

The Defense Contract Audit Agency completed all reports issued. This data is also reported in the Department of Defense OIG's Semiannual Report to Congress.

APPENDIX C

CONTRACT REVIEW REPORTS FOR WHICH A CONTRACTING OFFICER DECISION HAD NOT BEEN MADE FOR OVER 6 MONTHS

Report Title, Number, and Issue Date	Questioned Costs	Recommended Better Use of Funds	Reason for Delay and Planned Date for a Decision
Contract Reviews by OIG			
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT			
Audit of Claims and Requests for Equitable Adjustments Submitted by Bay Construction Company, Contract Number V662C-1439, 8PE-E10-082, 3/25/98		$394,154	Claim in litigation; no planned resolution date available.
Audit of Claim for Alleged Damages Under an Agreement with a VAMC, 8PE-A12-104, 7/1/98		$318,008	Claim in litigation; no planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Baxter Healthcare Corporation, Deerfield, IL, 9PE-X01-022, 2/4/99		$2,409,502	Pending receipt of Contracting Officer Price Negotiation Memorandum (PNM); anticipated award date is October 31, 2000.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-QF-98), Everest & Jennings, Earth City, MO, 9PE-E02-036, 2/23/99		$680,400	Pending receipt of Contracting Officer PNM; anticipated award date is December 31, 2000.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97 OSI) Ortho-McNeil Pharmaceutical, Inc., Raritan, NJ, 99-00143-017, 11/10/99		$18,747,758	Pending receipt of Contracting Officer PNM; anticipated award date is October 31, 2000.
Review of Alternate Federal Supply Schedule Pricing Proposal (Solicitation Number M6-Q5-98), Circon ACMI, Stamford, CT, 00-00795-040, 2/8/00		$1,006,434	Pending receipt of Contracting Officer PNM; no planned decision date available.

Report Title, Number, and Issue Date	Recommended Better Use of Funds	Unsupported Costs	Reason for Delay and Planned Date for a Decision
Contract Reviews by Other Agencies			
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT			
Claim, Contract V101DC-0048, Expand/Renovate Bldg-1, VAMC Salt Lake, Interwest Construction Salt Lake City, UT, 7PE-N03-114, 9/30/97	$1,469,934		Claim in litigation; no planned resolution date available.
Claim, Contract No. V621C-505, Correct Lake Drainage, VAMC Mountain Home, TN, Carpenter Construction, Inc., Robbinsville, NC, 9PE-N03-107, 5/12/99	$300,626		Claim in litigation; no planned resolution date available.
Proposal, Project No. 543-015, Sprinkler & Fire Alarm Pro., VAMC Columbia, SC, Fire Security System, Inc., Bossier City, LA, 9PE-N03-108, 7/27/99	$1,109,745		Claim in litigation; no planned resolution date available.
Claim, Contract No. V640P-5285, Transportation Services, VA HCS Palo Alto, Bay Trans Company, Inc., Santa Clara, CA, 9PE-N03-111, 8/18/99	$1,463,111		Claim in appeal; no planned resolution date available.
OFFICE OF FACILITIES MANAGEMENT (VHA)			
Adjustment Claim, V101C-1606, Construction Service, VAMC Albany, Bhandari Constructors Inc., Syracuse, NY, 5PE-N02-007, 3/31/95	$271,599		Negotiation not finalized; planned resolution by June 30, 2001.
Claim, Contract V101C-1532, Asbestos Removal VAMC W. Roxbury, Saturn Construction Co., Inc., Valhalla, NY, 5PE-N02-006, 2/23/96	$875,708	$1,898	Negotiation not finalized; planned resolution by June 30, 2001.
Proposal, Project No. 672-045, Change Order Outpatient Clinic Addition, VAMC San Juan, J. A. Jones Construction Co., San Juan, PR, 7PE-N02-007, 12/9/97	$284,827		Negotiation not finalized; planned resolution by January 15, 2001.
Claim, Contract No. V101BC131, Ambulatory Care Addition, VAMC San Juan, J. A. Jones Construction Co., Charlotte, NC, 9PE-N02-013, 4/6/99	$3,787,571		Negotiation not finalized; planned resolution by January 15, 2001.
Proposal, Project No. 614-011, Seismic/Modernization, VAMC Memphis, Caddell Construction, 9PE-N02-007, 9/15/99	$1,912,868		Negotiation not finalized; no planned resolution date available.
Claim, Contracting No. V101CC-0052, Construction, VAMC Detroit, Centex Construction Company, Dallas, TX, 1999-03107-PE-0107-N02, 10/26/99	$24,261,851		Negotiation not finalized; no planned resolution date available.

Report Title, Number, and Issue Date	Recommended Better Use of Funds	Unsupported Costs	Reason for Delay and Planned Date for a Decision
OFFICE OF FACILITIES MANAGEMENT (VHA) (Cont'd)			
Claim, Project No. 317-007, Construction, VARO St. Petersburg, J. Kokolakis Contracting, Inc., Tarpon Springs, FL, 1999-03115-PE-0201-N02, 12/22/99	$2,866,738		Negotiation not finalized; no planned resolution date available.
Claim, Project No. 508-018C, Clinical Addition, VAMC Atlanta, Caddell Construction, Co., Montgomery, AL, 1999-03095-PE-0001-N02, 12/29/99	$2,187,794		Negotiation not finalized; no planned resolution date available.
Claim, Contract No. V101AC0141, Construction, VAMC Mt. Home, Summit Construction Company, Inc., Cuyahoea Falls, OH, 2000-00021-PE-0002-N02, 3/21/00	$149,760		Negotiation not finalized; no planned resolution date available.
OFFICE OF THE GENERAL COUNSEL			
Claim, Project No. 690-035 MFI Addition, VAMC Brockton, Saturn Construction Co., Inc., Valhalla NY, 6PE-N02-001, 5/19/97	$724,755		General Counsel in settlement discussions; no planned resolution date available.
Proposal, Project No. 543-015, Sprinkler & Fire Alarm Pro, VAMC Columbia Fire Security Systems, Inc., Bossier City, LA, 8PE-N03-110, 3/19/98	$503,356		Claim in litigation; planned resolution by January 31, 2001.
Claim, Contract V101C-1651, Environment Improvement, VAMC North Chicago, Blount Inc., 4PE-N02-202, 2/7/96	$7,370,861		General Counsel in settlement discussions; no planned resolution date available.

APPENDIX D

FOLLOW UP/RESOLUTION OF OIG RECOMMENDATIONS

The Inspector General Act Amendments of 1988 require identification of all significant management decisions with which the Inspector General is in disagreement and all significant and other recommendations unresolved for over 6 months (management decisions not made). We had no Inspector General disagreements on significant management decisions and there were no internal audit recommendations unresolved for over 6 months as of the end of this reporting period. Contract report recommendations unresolved for over 6 months are included in Appendix C.

Following are tables which provide a summary of the number of OIG reports with potential monetary benefits that were unresolved at the beginning of the period, the number of reports issued and resolved during the period with potential monetary benefits, and the number of reports that remained unresolved at the end of the period.

As required by the IG Act Amendments, Tables 1 - 3 provide statistical summaries of unresolved and resolved reports for this reporting period. The dollar figures used throughout this report are based on the definitions included in the IG Act Amendments of 1988. The figures may reflect changes from the data in the individual reports due to OIG validation to ensure compliance with the IG Act Amendments definitions.

TABLE 1 - SUMMARY OF UNRESOLVED AUDIT REPORTS

Table 1 provides a summary of all unresolved reports and the length of time they have been unresolved.

MONTHS	TYPE AUDIT	NUMBER	TOTAL
Over 6 Months	Internal Audit	0	22
	Contract Review	22	
Less Than 6 Months	Internal Audit	0	6
	Contract Review	6	
		TOTAL	**28**

Tables 2 and 3 show a total of 27 reports that were unresolved as of September 30, 2000. This number differs from the 28 reports shown above because tables 2 and 3 include only reports with monetary benefits as required by the IG Act Amendments. Tables 2 and 3 also provide the reports resolved during the period with the OIG estimates of disallowed costs and funds to be put to better use, including those in which management agreed to implement OIG recommendations and those in which management did not agree to implement OIG recommendations. The Assistant Secretary for Management maintains data on the agreed upon reports and Management estimates of disallowed costs and funds to be put to better use in order to comply with the reporting requirements for the Secretary's Management Report to Congress, required by the IG Act Amendments.

TABLE 2 - RESOLUTION STATUS OF REPORTS WITH QUESTIONED COSTS

Table 2 summarizes reports, the dollar value of questioned costs, and the costs disallowed and allowed.

RESOLUTION STATUS	NUMBER OF REPORTS	QUESTIONED COSTS (In Millions)
No management decision by 3/31/00	0	$0
Issued during reporting period	14	$3.9
Total Inventory This Period	**14**	**$3.9**
Management decision during reporting period		
Disallowed costs (agreed to by management)	14	$3.9
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Period	**14**	**$3.9**
Total Carried Over to Next Period	**0**	**$0**

Definitions:

- **Questioned Costs**

For audit reports, it is the amounts paid by VA and unbilled amounts for which the OIG recommends VA pursue collection, including Government property, services or benefits provided to ineligible recipients; recommended collections of money inadvertently or erroneously paid out; and recommended collections or offsets for overcharges or ineligible costs claimed.

For contract review reports, it is contractor or grantee costs OIG recommends be disallowed by the contracting officer, grant official, or other management official. Costs normally result from a finding that expenditures were not made in accordance with applicable laws, regulations, contracts, grants, or other agreements; or a finding that the expenditure of funds for the intended purpose was unnecessary or unreasonable.

- **Disallowed Costs** are costs that contracting officers, grant officials, or management officials have determined should not be charged to the Government and which will be pursued for recovery; or on which management has agreed that VA should bill for property, services, benefits provided, monies erroneously paid out, overcharges, etc. Disallowed costs do not necessarily represent the actual amount of money that will be recovered by the Government due to unsuccessful collection actions, appeal decisions, or other similar actions.

- **Allowed Costs** are amounts on which contracting officers, grant officials, or management officials have determined that VA will not pursue recovery of funds.

TABLE 3 – RESOLUTION STATUS OF REPORTS WITH RECOMMENDED FUNDS TO BE PUT TO BETTER USE BY MANAGEMENT

Table 3 summarizes reports with Recommended Funds to be Put to Better Use by management, and the dollar value of recommendations that were agreed to and not agreed to by management.

RESOLUTION STATUS	NUMBER OF REPORTS	RECOMMENDED FUNDS TO BE PUT TO BETTER USE (In Millions)
No management decision by 3/31/00	40	$156.0
Issued during reporting period	19	$36.8
Total Inventory This Period	**59**	**$192.8**
Management decisions during reporting period		
Agreed to by management	29	$90.3
Not agreed to by management	3	$26.9
Total Management Decisions This Period	**32**	**$117.2**
Total Carried Over to Next Period	**27**	**$75.6**

Definitions:

- **Recommended Better Use of Funds**

For audit reports, it represents a quantification of funds that could be used more efficiently if management took actions to complete recommendations pertaining to deobligation of funds, costs not incurred by implementing recommended improvements, and other savings identified in audit reports.

For contract review reports, it is the sum of the questioned and unsupported costs identified in preaward contract reviews which the OIG recommends be disallowed in negotiations unless additional evidence supporting the costs is provided. Questioned costs normally result from findings such as a failure to comply with regulations or contract requirements, mathematical errors, duplication of costs, proposal of excessive rates, or differences in accounting methodology. Unsupported costs result from a finding that inadequate documentation exists to enable the auditor to make a determination concerning allowability of costs proposed.

- **Dollar Value of Recommendations Agreed to by Management** provides the OIG estimate of funds that will be used more efficiently based on management's agreement to implement actions, or the amount contracting officers disallowed in negotiations, including the amount associated with contracts that were not awarded as a result of audits.

- **Dollar Value of Recommendations Not Agreed to by Management** is the amount associated with recommendations that management decided will not be implemented, or the amount of questioned and/or unsupported costs that contracting officers decided to allow.

APPENDIX E

REPORTING REQUIREMENTS OF THE INSPECTOR GENERAL

The table below cross-references the reporting requirements to the specific pages where they are prescribed by the Inspector General Act of 1978 (Public Law 95-452), as amended by the Inspector General Act Amendments of 1988 (Public Law 100-504), and the Omnibus Consolidated Appropriations Act of 1997 (Public Law 104-208).

IG Act References	Reporting Requirement	Page
Section 4 (a) (2)	Review of legislation and regulations	71
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-78
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-78
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	97
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	i
Section 5 (a) (5)	Summary of instances where information was refused	81
Section 5 (a) (6)	List of audit reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use	83 to 91 (App. A & B)
Section 5 (a) (7)	Summary of each particularly significant report	i to v
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	98 (Table 2)
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	99 (Table 3)
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	93 to 95 (App. C)
Section 5 (a) (11)	Significant revised management decisions	None
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	None
Section 5 (a) (13)	Information described under section 05(b) of the Federal Financial Management Improvement Act of 1996 (Public Law 104-208)	50

APPENDIX F

OIG OPERATIONS PHONE LIST

Investigations

Central Office Investigations Washington, DC .... (202) 565-7702
Northeast Field Office (51NY) New York, NY .... (212) 807-3444
Boston Resident Agency (51BN) Bedford, MA .... (781) 687-3138
Newark Resident Agency (51NJ) Newark, NJ .... (973) 645-3590
Pittsburgh Resident Agency (51PB) Pittsburgh, PA .... (412) 784-3818
Washington Resident Agency (51WA) Washington, DC .... (202) 691-3338
Southeast Field Office (51SP) Bay Pines, FL .... (727) 398-9559
Atlanta Resident Agency (51AT) Atlanta, GA .... (404) 929-5950
Columbia Resident Agency (51CS) Columbia, SC .... (803) 695-6707
Nashville Resident Agency (51NV) Nashville, TN .... (615) 736-7200
New Orleans Resident Agency (51NO) New Orleans, LA .... (504) 619-4340
West Palm Beach Resident Agency (51WP) West Palm Beach, FL .... (561) 882-7720
Central Field Office (51CH) Chicago, IL .... (708) 202-2676
Dallas Resident Agency (51DA) Dallas, TX .... (214) 655-6022
Denver Resident Agency (51DV) Denver, CO .... (303) 331-7673
Houston Resident Agency (51HU) Houston, TX .... (713) 794-3652
Kansas City Resident Agency (51KC) Kansas City, KS .... (913) 551-1439
Western Field Office (51LA) Los Angeles, CA .... (310) 268-4268
Phoenix Resident Agency (51PX) Phoenix, AZ .... (602) 640-4684
San Francisco Resident Agency (51SF) Oakland, CA .... (510) 637-1074

Healthcare Inspections

Central Office Operations Washington, DC .... (202) 565-8305
Healthcare Regional Office Atlanta (54AT) Atlanta, GA .... (404) 929-5961
Healthcare Regional Office Chicago (54CH) Chicago, IL .... (708) 202-2672
Healthcare Regional Office Los Angeles (54LA) Los Angeles, CA .... (310) 268-3005

OIG OPERATIONS PHONE LIST (CONT'D)

Audit

Central Office Operations Washington, DC .... (202) 565-4625
Central Office Operations Division (52CO) Washington, DC .... (202) 565-4434
Contract Review and Evaluation Division (52C) Washington, DC .... (202) 565-4818
Financial Audit Division (52CF) Washington, DC .... (202) 565-7913
Austin Residence (52AU) Austin, TX .... (512) 326-6216
Operations Division Atlanta (52AT) Atlanta, GA .... (404) 929-5921
Operations Division Boston (52BN) Bedford, MA .... (781) 687-3120
Philadelphia Residence (52PH) Philadelphia, PA .... (215) 381-3052
Operations Division Chicago (52CH) Chicago, IL .... (708) 202-2667
Operations Division Dallas (52DA) Dallas, TX .... (214) 655-6000
Operations Division Kansas City (52KC) Kansas City, MO .... (816) 426-7100
Operations Division Los Angeles (52LA) Los Angeles, CA .... (310) 268-4335
Operations Division Seattle (52SE) Seattle, WA .... (206) 220-6654

APPENDIX G

GLOSSARY

ADP	Automated Data Processing
BVA	Board of Veterans' Appeals
CAP	Combined Assessment Program
C&P	Compensation & Pension
CFS	Consolidated Financial Statements
CIO	Chief Information Officer
DCIS	Defense Criminal Investigative Service
DEA	Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
DoD	Department of Defense
DoL	Department of Labor
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FFMIA	Federal Financial Management Improvement Act
FOIA	Freedom of Information Act
FTE	Full Time Equivalent
FY	Fiscal Year
GPRA	Government Performance and Results Act
HHS	Department of Health and Human Services
HRA	Human Resources and Administration
HUD	Department of Housing and Urban Development
IRS	Internal Revenue Service
IG	Inspector General
IT	Information Technology
MCI	Master Case Index
NCA	National Cemetery Administration
NHCU	Nursing Home Care Unit
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
OMB	Office of Management and Budget
PCIE	President's Council on Integrity and Efficiency
PNM	Price Negotiation Memorandum
QM	Quality Management
SSA	Social Security Administration
USSS	United States Secret Service
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VAMROC	Veterans Affairs Medical and Regional Office Center
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WCP	Workers' Compensation Program

Copies of this report are available to the public. Written requests should be sent to:

Office of the Inspector General (53B)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

The report is also available on our Web Site:

http://www.va.gov/oig/53/semiann/reports.htm

For further information regarding VA's OIG, you may call 202 565-8620

Cover photo of
The Vietnam Women's Memorial,
Washington, DC