# I. SIGNIFICANT OPERATIONAL ACTIVITIES

## MEDICAL CARE PROGRAMS

### 1. RESOURCE UTILIZATION

**Issue: Lithotriper Utilization**

**Conclusion: Veterans Health Administration (VHA) can reduce lithotripsy costs by improved management of existing units and realignment and consolidation of resources.**

**Impact: $2.73 million potential Better Use of Funds.**

We audited the use of lithotripters in VHA to determine if existing lithotripsy units were operating economically and efficiently, and were sufficient to meet VHA's workload. Lithotripters are used to crush kidney and urinary tract stones with shock waves and cost between $725,000 and $1.9 million each. We found that, in Fiscal Year (FY) 1995, the 12 VA medical centers (VAMCs) with VA-owned lithotripters performed only 1,626 procedures, about 11 percent of total capacity. We concluded that additional capacity is not needed. We recommended realignment and consolidation of lithotripsy capability by designation of six lithotripsy resource centers, closure of other lithotripsy suites as equipment becomes obsolete, and cancellation of any planned lithotripsy suites. We also recommended several actions to reduce lithotripsy operating costs, including providing treatment on an outpatient basis, whenever possible; using in-house maintenance; and improving contract administration over shared resources. These recommendations could result in a savings of $2.73 million.

The Under Secretary for Health provided an acceptable alternative to our realignment proposal, tasking the Network Clinical Managers to assess various options in obtaining lithotripsy services, including selling excess capacity and increasing the use of contracts for community services. The Under Secretary also agreed to develop guidelines for best practices in managing lithotripter units, and canceled two planned lithotripsy suites, with the cancellations estimated to result in a $2.2 million better use of funds. We consider all issues in the report resolved. (*Audit of Lithotripter Utilization*)

**Issue: Use of Intergovernmental Personnel Act (IPA) Assignments**

**Conclusion: VHA needs additional policy guidance to help ensure the appropriate use of IPA assignments.**

**Impact: $1.3 million potential Better Use of Funds.**

This audit was conducted as part of our ongoing review of affiliation issues. IPAs are used to temporarily obtain skilled personnel, with VAMCs the largest users, primarily to obtain medical school employees on a temporary basis to work on research projects. In FY 1996, we estimated that VAMCs had over 1,000 IPA agreements in use at a cost of over $34 million.

We first reviewed use of IPAs at one VAMC, the largest user of IPAs, and expanded the review to two other VAMCs. At all three VAMCs, we found IPA use to support research activities was in compliance with IPA regulations, but IPAs were inappropriately used to obtain clinical services and for administrative and support positions. In addition, the largest user did not have adequate controls to prevent IPA overpayments, with excessive payments estimated at $1.3 million annually. Based on our initial findings, the Under Secretary for Health initiated immediate action by issuing a reminder to VHA field facilities which outlined the purpose of IPA assignments and emphasized the need for compliance with IPA regulations. He also agreed with our recommendation to issue detailed guidance on the use of IPA assignments. Based on these actions, we terminated the planned nation-wide review. (*Audit of VAMC Use of IPA Assignments)*

## 2. PROGRAMS FOR ELDERLY VETERAN PATIENTS

**Issue: Prescribing Practices for Elderly Outpatients**

**Conclusion: VHA can help optimize medication management for specific drugs and patient populations by providing data on drug specific prescribing practices to VHA managers and clinicians.**

**Impact: Medication management for elderly veterans improved.**

We conducted a review of VHA's prescribing practices for selected drugs issued to outpatients aged 65 or older. The purpose of the review was to help VHA: (i) assess how well it manages certain medications for the elderly, and (ii) develop management tools for health care providers to monitor and optimize medication management for the elderly.

Studies published in The Journal of the American Medical Association (JAMA) in 1994 and by the General Accounting Office (GAO) in 1995 concluded that between 17.5 and 25 percent of noninstitutionalized

elderly patients were taking one or more of 20 prescription drugs that many experts regard as generally unsuitable for their age group.

Our review focused on 4 of the 20 drugs reported in JAMA and by the GAO. Based on a nation-wide review of prescribing practices for these four drugs, we found that, during the first 6 months of FY 1996, VHA providers prescribed these four drugs to elderly outpatients substantially less frequently than non-VA providers as reported in both the 1994 JAMA article and the 1995 GAO report. During our review at one VAMC, we found that by providing VAMC managers and clinicians information regarding their prescribing practices for these drugs, prescribing practices changed to further improve medication management for elderly patients. We recommended that VHA provide information regarding prescribing practices to all VHA facilities and to incorporate automated data processing applications developed for the review into the national Decentralized Hospital Computer Program system. The Under Secretary for Health concurred with the findings and recommendations and provided acceptable implementation plans. We consider all issues resolved. *(Review of Prescribing Practices for Elderly Outpatients)*

**Issue: Geriatric Research, Education, and Clinical Centers (GRECC) Program**

**Conclusion: The GRECC program is meeting its mission to improve care to elderly veterans, but services could be enhanced further by establishing GRECC-developed treatment models and educational programs at more VA facilities.**

**Impact: Expansion of programs for elderly veterans to other facilities.**

We evaluated the effectiveness of VA's GRECC program in meeting the needs of elderly veteran patients. Annual GRECC program costs total approximately $24 million. During FY 1995, funding for research totaled $77 million. We concluded that the GRECC program was meeting its mission, and recommended that the Under Secretary for Health develop a method for establishing GRECC-developed treatment models and educational programs at more VA facilities. The Under Secretary for Health concurred with our conclusions and recommendation and provided an acceptable implementation plan. *(Audit Of Department of Veterans Affairs GRECC Program)*

## 3. REQUESTED MANAGEMENT OVERSIGHT REVIEW

**Issue: Financial and Management Oversight of the Home Improvement and Structural Alterations (HISA) Program**

**Conclusion: VA should define allowable HISA services, better identify eligible veterans for the program, and strengthen financial management.**

**Impact: Improved program for disabled veterans.**

We initiated this audit at the request of the Under Secretary for Health to evaluate the financial and management oversight of the HISA program. The HISA program was established in October 1976 to assist veterans who needed home improvements or structural alterations to provide accessibility to the home or ensure continuation of treatment in the home, rather than in a hospital or nursing home. HISA program costs increased from $1.9 million in FY 1991 to over $4 million in FY 1996. Overall, the program was accomplishing its intended purpose of allowing veterans better access to their homes. We made recommendations to improve the definition of eligible projects/ services, and to improve financial management of the program. The Under Secretary for Health concurred with the recommendations and provided acceptable implementation plans. We consider all audit issues resolved. (*Audit of the HISA Program)*

## 4. NATION-WIDE PATIENT CARE PROGRAM REVIEWS

**Issue: Advance Directives for End-of-Life Decisions**

**Conclusion: The VHA has aggressively pursued and supported patients' rights to decide the extent to which VHA clinicians should attempt to prolong their lives in the final stages of illness.**

**Impact: Improved procedures.**

In November 1991, VHA implemented a Living Will/Advance Directive program to facilitate patients abilities to direct their care. The term, Advance Directive, refers to competent adults' specific oral and written statements as to their desires for withholding or withdrawal of life-sustaining treatments. We conducted a review to evaluate VHA's efforts to ensure that patients have the opportunity to dictate the measures that clinicians will take to prolong their lives in the final stages of terminal illnesses.

We found that VHA clinical employees closely adhere to the guidance and philosophy that patients have a right to decide on this important issue, that they take every reasonable action to keep patients

comfortable, and/or provide procedures that alleviate pain and suffering before the end-of-life events occur. In certain cases, lacking patients' future ability to make these decisions, the patients may appoint family members as surrogates to make the decisions for them. We found that employees consistently adhere to surrogates' wishes as well. We found that social workers are in the vanguard of discussing these issues with patients and their family members. We also found that VHA's advance directive forms are written in complex language that exceeds the average VA patients' reading ability, and this many times intimidates patients and their families to the extent that they are reluctant to initiate the advance directive actions. We recommended that physicians become more involved with counseling patients at the appropriate times. We also encouraged the Under Secretary for Health to consider revising existing guidance that allows employee counseling on this issue only after the patient is hospitalized such that employees may initiate the discussions while the patient is in an outpatient setting, and is less intimidated by the environment.

The Under Secretary for Health concurred in our recommendations and implemented or planned appropriate actions to strengthen advance directive procedures. *(Evaluation of the VHA's Advanced Directive Program)*

**Issue: Nation-wide Quality Program Assistance (QPA) Reviews**

**Conclusion: VAMC top managers were individually and collectively involved in several actions that were focused on ensuring that eligible veterans have access to high-quality, low-cost health care.**

**Impact: Advisory report.**

We conducted a QPA review at VAMC Durham, as part of our QPA development process. The QPA process is intended to add value to other external review activities that oversee VHA facilities. Review instruments assess the extent to which VHA's four performance goals: (i) cost-efficient care, (ii) high quality care, (iii) improved patient access to care, and (iv) improved patient satisfaction, are being met.

We concluded that the VAMC's top managers were individually and collectively involved in several actions that were focused on ensuring that eligible veterans have access to high quality, low cost health care. In addition, mid-level managers and operating employees were aware of, and supported management's treatment goals, and patients indicated that they were generally pleased with the care they received. *(Quality Program Assistance Review, VAMC Durham, NC)*

## 5. AFFILIATION ISSUES

**Issue: Medical School Affiliations**

**Conclusion: VHA continues to make progress on affiliation issues and should pursue the renegotiation of affiliation agreements and avoid special arrangements.**

**Impact: Additional efforts to strengthen affiliations.**

This report summarizes the results of 16 OIG audits of affiliation-related activities conducted over the past 4 years, and Office of Audit observations of affiliation issues. Each year, more than 100,000 residents and students receive all or part of their training at VA facilities. In FY 1995, VA spent about $1.5 billion to directly or indirectly support affiliation activities. This included funding of about 8,900 medical resident positions at an estimated cost of $341 million. This means that VA supported about 9 percent of the medical residents in the United States. About 75 percent of VA's 173 medical centers are affiliated with medical school faculty appointments.

We found that VHA management had taken actions to respond to our specific recommendations and had made significant progress in addressing the issues of management of physician resources, contractual relationships with medical schools, and management information and resource allocation systems. To continue momentum in improving medical school affiliations, we recommended that VHA: (i) remind VAMC and network officials that they must avoid questionable special arrangements with affiliates, and (ii) pursue renegotiation of affiliation agreements.

The Under Secretary for Health concurred in the findings and recommendations and indicated that the report accurately reflected VHA's ongoing efforts to strengthen affiliation relations. VHA's implementation plan was acceptable, and we consider all issues to be resolved. *(Summary Report: Audits of VA Medical School Affiliation Issues)*

**Issue: Alleged Inadequate Anesthesiology Quality Management Procedures**

**Conclusion: A lack of adequate monitoring of anesthesiology procedures compromised managers' ability to know if patients were receiving consistently high quality care.**

**Impact: Anesthesiology quality management procedures established.**

We reviewed allegations of multiple administrative and clinical deficiencies involving anesthesia operations at VAMC Richmond. Several patients had reportedly been harmed by improperly performed anesthesia and cardiac surgical procedures, equipment failures reportedly resulted in patient injuries, and Anesthesiology Service allegedly did not have adequate quality management procedures in place to identify and evaluate these incidents or to correct the problems that allowed them to occur.

We found that several patients had experienced untoward or unwanted events during the course of their treatment in the operating room. Anesthesiology Service did not have procedures in place to identify and monitor the types of events that occurred, and the Service chief did not have any way of evaluating or correcting staff performance on a continuing basis. We also found, however, that Surgical Service had a highly effective quality management monitoring and tracking system, and all of the cases that the complainant raised had been discussed in the context of Surgical Service staff meetings. In addition, corrective actions had been initiated to reduce the possibility that similar incidents would recur. The review also found that operating room employees had not reported malfunctions of emergency equipment because they interpreted Department policy to mean that incidents that occurred in the operating room were to be managed and corrected by operating room staff.

We concluded that lack of an anesthesiology quality management process provided an environment in which improper anesthesia treatment practices could occur without being detected or corrected, and that inconsistent reporting of patient incidents in the operating room inhibited medical center managers' ability to identify equipment-related malfunctions, and correct them in a timely manner. The medical center director took appropriate actions subsequent to our inspection to correct the identified problems. (*Inspection of Selected Clinical and Administrative Issues on Anesthesiology Service, Hunter Holmes McGuire VAMC Richmond, VA)*

**Issue: Alleged Release of a Potentially Dangerous Patient from Inpatient Care**

**Conclusion: Medical center clinicians properly evaluated and treated the patient.**

**Impact: Assurance of proper care to a veteran.**

We reviewed a family's concerns that medical center clinicians had not properly evaluated a patient's potential for committing violent acts, and that their proposal to discharge a patient from care threatened the family's safety and security. We found that the patient had been admitted to the medical center on a court order because of homicidal and suicidal ideations. He had a lengthy hospitalization, was no longer subject to a court order, was being housed in the domiciliary, and could leave the hospital grounds of his own free will. Because he was not under a court order, clinicians had no legal right to keep him in the hospital. In addition, the patient's brother had requested his release to live with him and his family, and had assured clinicians of ongoing monitoring, including followup in a mental health clinic. The patient had left the medical center and traveled to his brother's home without incident. We concluded that clinicians had carefully and thoroughly monitored and evaluated his condition and behaviors. No recommendations were made. *(Inspection of Alleged Premature Discharge of a Potentially Violent Patient From a Psychiatric Unit at the Franklin Delano Roosevelt VA Hospital Montrose, NY)*

**Issue: Alleged Clinical and Administrative Mismanagement**

**Conclusion: Patient care met or exceeded accepted standards; lack of trust between employees and their patients and family members lowered morale, and made employees unsure of how to treat their patients.**

**Impact: Team building program established to improved morale/ services.**

We reviewed allegations that managers at VAMC Prescott had failed to address serious concerns about patient abuse, theft of patients' valuables, and various administrative deficiencies on the nursing home care unit (NHCU). In addition, managers had allegedly covered up these issues and therefore staff could not trust them to correct other identified problems. Inspectors found that managers had conducted several administrative investigations and preliminary inquiries into each of the employees' allegations, and they had implemented several actions to correct the problems. They rightfully had not communicated all of their actions to the employees, and not all of the corrective actions were apparent. Specifically, managers had conducted a comprehensive investigation into charges of patient abuse, and an employee was terminated as a result of the

investigative findings. In addition, another employee was arrested by OIG investigators for stealing a NHCU patient's funds and diverting them to her own use.

Inspection concluded that these high-profile incidents had shaken employees' confidence in their ability to properly treat their patients without being charged with ethics violations, and had shaken their trust in their fellow employees as well. In addition, there was a mutual distrust between employees, and patients and their families based on these high-profile incidents. The inspection also found that medical center clinical service chiefs did not include NHCU clinicians in routine staff meeting deliberations, so clinicians felt alienated from their colleagues; and the recruitment of volunteers for NHCU assignments could potentially provide a degree of latitude for employees to divert time from direct patient care activities to the extent that they could provide more personalized services to their patients.

We recommended that the Director initiate team building and confidence building for the NHCU staff, and that clinical service chiefs be encouraged to bring their NHCU-based employees into the mainstream of their respective staffs. We also recommended that the Director encourage the Chief of Voluntary Service to work with NHCU nursing managers to develop statements of meaningful work that regularly scheduled volunteers would find interesting, and that the Chief of Voluntary Service recruit interested volunteers to staff these positions. The Director took immediate action to implement the recommendations. *(Inspection of Alleged Patient Abuse and Substandard Patient Care on the NHCU, VAMC Prescott, AZ)*

## 7. PATIENT CARE ISSUE

**Issue: Investigation of Patient Death**

**Conclusion: The patient was murdered.**

**Impact: Unusual incident with no VA-wide implications.**

An individual who was a patient at a VAMC was convicted of first degree murder in the death of a second patient following a jury trial in U.S. District Court. Initially, it was believed that the victim had suffered fatal injuries after falling down a flight of stairs. However, a joint investigation conducted by the OIG and the Federal Bureau of Investigation revealed that he had suffered multiple injuries to the head caused by a blunt instrument and had defensive wounds to his hands. The individual faces a mandatory life sentence.

## 8. CONTROL OF DRUGS

**Issue: Illegally Obtained Drugs**

**Conclusion: Investigations disclosed fraudulent acts by individuals to obtain drugs.**

**Impact: Individuals are held accountable for illegal acts.**

- A former VAMC pharmacy technician pleaded guilty in U.S. District Court to one count of conspiracy to steal Government property. The technician admitted that, over the course of several years, he stole large quantities of high value pharmaceuticals from the medical center where he worked and sold those pharmaceuticals to the owners of a large retail pharmacy operation. The thefts occurred on a regular basis and, over the life of the scheme, he was paid between $75,000-$100,000. While the exact amount of the stolen drugs cannot be determined, the value was well in excess of what he was paid. Sentencing is pending.

- Another VAMC pharmacy technician pleaded guilty in U.S. District Court to the theft of Government property. An investigation disclosed that he misappropriated large quantities of non-controlled pharmaceuticals from the medical center pharmacy. Following discovery of the thefts, he resigned his position.

## 9. FEE-BASIS FRAUD

**Issue: Investigation of Suspected Fraudulent Claims**

**Conclusion: Individual submitted false invoices for services not provided.**

**Impact: Individual is held accountable for illegal acts.**

A physical therapist, who provided services to veterans under VA's fee-basis program, entered into a settlement agreement with the Department of Justice requiring the therapist to make monetary restitution to the Government. A proactive OIG investigation of fee basis fraud disclosed that the therapist submitted false invoices to VA for home-based healthcare services to veterans which he did not provide.

## 1. DELIVERY OF BENEFITS AND SERVICES

**Issue: Compensation and Pension (C&P) Overpayments**

**Conclusion: Veterans Benefit Administration (VBA) can further enhance overpayment prevention efforts and reduce program costs.**

**Impact: $30.4 million potential Better Use of Funds.**

We reviewed the causes of C&P overpayments valued at $120 million outstanding as of the end of FY 1995. Overpayments occurred when beneficiaries received money to which they are not entitled, generally as a result of changes in their entitlement status (income, dependency, hospitalization status, or death).

We estimated that overpayments valued at $26.2 million could be prevented annually if VBA policy and procedures are revised and cases are properly processed. C&P overpayments could be further reduced by $4.2 million annually, if the program is simplified and beneficiaries timely report beneficiary status changes.

We recommended that VBA reduce C&P overpayments by: (a) directing VA regional office (VARO) staff to make overpayment prevention a continuous special focus area of their quality reviews; (b) gathering and disseminating innovative best practices that help prevent overpayments; (c) revising due process notification procedures for veterans receiving long-term care, fiduciaries of incompetent veterans, dependent school children, and for beneficiaries reporting status changes that result in a reduction of benefits; (d) revising procedures for certain cases involving direct deposit of benefit payments; and (e) encouraging VAROs to enlist the assistance of veterans services organizations to improve timeliness of status changes reported by beneficiaries.

Management is addressing the issue of overpayments as part of their National Performance Review and Business Process Reengineering initiatives. We also noted that VAROs have implemented innovative procedures to prevent overpayments. The Acting Under Secretary for Benefits concurred with the findings and recommendations and provided an acceptable implementation plan. Actions on our recommendations involving revision of due process procedures were considered consistent with current statutory, regulatory, and judicial requirements. *(Review of the Causes of VBA's C&P Overpayments)*

**Issue: Invested Funds for the Servicemen's Group Life Insurance (SGLI) and Veterans' Group Life Insurance (VGLI) Programs**

**Conclusion: VA needs more financial information in order to better supervise administration of invested insurance funds.**

**Impact: $3.8 million potential Better Use of Funds.**

The SGLI and VGLI are programs supervised by VBA and administered by a major insurance company, hereafter referred to as the Insurer. The Insurer reported $32 million and $40 million of program earnings from investments, respectively, during calendar years 1993 and 1994. We audited the administration of invested funds for the SGLI and VGLI programs to assess the accuracy, reliability, and sufficiency of the Insurer's financial information.

We found that investment expenses were deducted from income, and that funds were transferred to the Insurer without being reported to VA. Although the governing legislation and provisions of group insurance policy did not require the Insurer to report this information to VA, its absence impeded VA management's ability to fully assess the accounting of invested funds and program reserves, and determine whether program investment earning could be enhanced. As a result of the audit, the Insurer agreed to a restoration of $3.8 million to invested assets and a reimbursement of lost income to the SGLI and VGLI programs' reserve of $3.2 million.

We recommended that VBA determine whether the Insurer's estimates of previous interbranch charges to program funds, including those described as "Dividends to Stockholder", are reasonable and whether the Insurer's proposed $3.8 million restoration to invested assets and $3.2 million reimbursement to program reserves are equitable. We further recommended that the Director, Insurance Service obtain more information about program financial operations, verify the accuracy of the insurer's accounting of SGLI and VGLI investment funds, clarify the Insured's equity in program funds, and assess whether opportunities exist to enhance program earnings. The Under Secretary for Benefits concurred with the recommendations and provided an acceptable implementation plan. *(Administration of Invested Funds for the SGLI and VGLI Programs)*

**Issue: Waiver Decisions For C&P Debts**

**Conclusion: Improvements in the quality and uniformity of waiver decisions are needed.**

**Impact: $2.9 million potential Better Use of Funds.**

We conducted a review to evaluate the quality of decisions to waive the collection of C&P debts, and to assess Committee on Waivers and Compromises (COWC) program policies and operating procedures. During

FY 1995, VBA waived beneficiary debts to VA valued at about $67 million. Our review covered COWC operations during FY 1995 and the first half of FY 1996.

We conducted a stratified statistical analysis on debts valued at $11.6 million and found waiver decisions in 30 percent of the debt cases reviewed were not supported by the evidence of record. Based on our sample results, we estimated that decisions to waive debts valued at $2.9 million were questionable. We also found a wide variance in decision results among the VAROs, with individual VAROs granting from 27 percent to 5 percent of waiver requests. We found that 11 VAROs granted waivers for over 70 percent of the cases, while 7 VAROs granted waivers in under 40 percent of the cases. The variance demonstrates a difference in the application of waiver criteria and results in unequal treatment of similarly situated beneficiaries who submit waiver requests.

We recommended that the Acting Under Secretary for Benefits improve the quality of decisions by enhancing guidance, conducting training, requiring more thorough quality reviews of waiver cases, and increasing VA Central Office oversight of the program. The Acting Under Secretary for Benefits concurred with the report recommendations and provided acceptable implementation actions. We considered all issues resolved. *(Review of Waiver Decisions for C&P Debts)*

**Issue: Data Reliability in the Claims Processing Workload Reporting System**

**Conclusion: Reliability of data in VBA's claims processing workload reporting system can be enhanced and opportunities exist to use beneficiary demographic data to estimate future workload requirements.**

**Impact: Increased accuracy and reliability of data.**

We audited data reliability in the workload reporting system at the request of VBA's Chief Financial Officer because of concerns that data were not sufficiently accurate to assure appropriate workload reporting and performance measurement of VBA operations. We identified opportunities for VBA to enhance the accuracy and reliability of workload reporting and performance measurement of claims processing operations, which can result in improved tracking of the delivery of benefits to beneficiaries. We also identified opportunities to use demographic data on beneficiaries derived from the C&P automated files as a tool to enhance predictions of future workload. The Acting Under Secretary for Benefits concurred with our recommendations, and provided acceptable implementation actions. We consider all issues resolved. (*Audit of VBA's Data Reliability in the Claims Processing Workload Reporting System)*

## 2. LOAN GUARANTY PROGRAM FRAUD

**Issue: Fraud in Loan Guaranty Program**

**Conclusion: The Loan Guaranty Program remains vulnerable to fraud involving loan origination.**

**Impact: Individuals are held accountable for illegal acts.**

- A credit counselor for a commercial firm was sentenced in U.S. District Court to 48 months' probation, fined $500, and ordered to perform 50 hours of community service. Investigation revealed that the counselor deleted derogatory credit information found on customer credit accounts. These alterations enabled the counselor's customers to secure home loans guaranteed by VA or insured by the Department of Housing and Urban Development, for which they otherwise might not have qualified.

- An individual was sentenced in U.S. District Court to 3 months' home detention and 3 years' probation. She previously pleaded guilty to making false statements after an investigation revealed that she submitted false information to VA concerning her identity and income in order to obtain a VA guaranteed mortgage.

- A real estate agent pleaded guilty in U.S. District Court to conspiracy to defraud VA. An investigation disclosed that the agent, along with several unindicted co-conspirators, submitted false information on loan documents to VA in order to purchase and obtain loans on VA-owned properties.

## 3. BENEFICIARY FRAUD

**Issue: Integrity of Beneficiary Programs**

**Conclusion: Fraud continues in pension, compensation, and fiduciary programs.**

**Impact: Individuals are held accountable for illegal acts.**

**Pension Fraud**

- An individual was sentenced in U.S. District Court to 9 months' imprisonment and 3 years' probation and ordered to make restitution to the Government. An investigation disclosed that the individual forged the signature of his deceased mother on 28 U.S. Treasury checks in order to misappropriate VA pension benefits intended for her.

- An individual pleaded guilty in U.S. District Court to five counts of theft of Government funds. An investigation revealed that the individual received VA pension benefits after he became employed at a VA medical center and reported no wages to the VA regional office. The loss to VA was $28,186. Sentencing is pending.

- An individual entered into a pretrial agreement with the U.S. Attorney's Office whereby she agreed to make restitution to VA in the amount of $36,884. An investigation revealed that the individual failed to notify VA of her annual income over an 8-year period in order to receive pension benefits to which she was not entitled.

**Compensation Fraud**

- An individual was sentenced in U.S. District Court to 12 months in prison, 3 years' supervised release, ordered to pay $50,057 in restitution to VA, and to forfeit property worth $12,265 which had been purchased with VA funds. She previously had pleaded guilty to a two-count indictment charging her with making false statements and concealing unearned income from the Social Security Administration. An investigation disclosed that the individual made numerous false statements to VA indicating she had actively served in the U.S. military where she claimed to have developed a disability in order to qualify for, and receive, compensation benefits to which she was not entitled. The resulting loss to VA was $64,904.

- An individual pleaded guilty in U.S. District Court to making false claims to the Government and to three counts of conspiracy. The individual's spouse pleaded guilty to conspiracy. The pleas were the result of an investigation which disclosed that the individual fraudulently collected $212,599 in service-connected compensation benefits from VA by falsely claiming that he suffered from schizophrenia. The scheme was perpetrated by submitting false information to VA and by effectively feigning the mental illness when he visited VA facilities for evaluation and therapy.

- A mid-level U.S. Department of Treasury employee was allowed to enter into a pre-trial diversion program after receiving VA compensation for 25 years at the 100 percent rate, based upon an initial claim of unemployability, and periodic certifications of his inability to work. However, an investigation disclosed that he was employed full-time. His entry in the pre-trial diversion program was contingent upon his agreement to perform 150 hours of community service and to waive any claim to his 80 percent VA compensation entitlement until the $144,120 he received improperly is recovered in full by VA.

- An individual was indicted by a Federal grand jury on 3 counts of making false claims to VA and 11 counts of theft of Government

funds. An investigation disclosed that the individual was receiving 100 percent service-connected compensation benefits based on unemployability for 14 years when, in fact, he was employed full-time as a teacher in a southern California school district. Loss to VA was $189,836.

- An individual was sentenced in U.S. District Court to 5 months in a community correctional center, 5 months' home confinement, 2 years' supervised probation, and was ordered to pay $102,032 in restitution to VA. The individual previously pleaded guilty to one count of theft of Government funds. Investigation disclosed that the individual misappropriated VA Dependency and Indemnity Compensation (DIC) benefits intended for her mother following the mother's death.

- An individual was sentenced in U.S. District Court to 3 years' probation, ordered to perform 300 hours of community service, and although restitution was not ordered, a civil judgment in the amount of $75,399 satisfied the Government's monetary loss for the criminal case. The individual previously pleaded guilty to two counts of mail fraud after an investigation revealed that for more than 20 years, the individual had fraudulently endorsed and negotiated VA DIC benefit checks which were issued in her deceased mother's name.

**Fiduciary Fraud**

- A former nursing home administrator was sentenced in U.S. District Court to 30 months' imprisonment and 5 years' probation. He previously was convicted of misappropriation by a fiduciary. An investigation revealed that he had embezzled money from incompetent residents at a home for adults, where he was the facility administrator. Among the funds misappropriated was a $122,658 retroactive VA compensation benefits check, issued to a resident veteran, which had been deposited improperly into the home's general operating account.

- An Oklahoma State highway patrol officer was found guilty of two counts of making false statements to the Government after a jury trial in U.S. District Court. An investigation revealed that the patrolman, who was a fiduciary for two disabled veterans, misappropriated $62,000 of their funds. He then provided fraudulent accounting documents to VA and to the State of Oklahoma in order to conceal the theft.

- A former veterans' agent, appointed as fiduciary for disabled veterans, pleaded guilty in Superior Court for the Commonwealth of Massachusetts to embezzlement of funds by a fiduciary and to receipt of an unlawful gratuity. An investigation revealed that the agent misappropriated in excess of $25,000 from a Korean War veteran, and at least $1,700 from a Vietnam War veteran. In addition, he accepted a house worth $66,800 as a gratuity from the widow of a World War II veteran, after he helped her qualify for veteran's

benefits and medical treatment. The agent was sentenced to 20 days in jail, 5 years' probation, ordered to return all assets to the veterans, and to resign his position with the state without receiving a pension.

- A former fiduciary was sentenced in U.S. District Court to 5 years' probation, 200 hours of community service, and ordered to make restitution to the Government in the amount of $21,891. He previously had pleaded guilty to 12 counts of theft of Government funds. An investigation revealed that the fiduciary failed to notify VA of the death of a veteran's widow and, over a 3-year period, misappropriated $27,891 in DIC benefits intended for the widow.

# PROCUREMENT PROGRAMS

## 1. CONTRACTOR OVERCHARGES

**Issue: Contractor Overcharges for Drugs, Medical Equipment and Supplies**

**Conclusion: Contract reviews disclosed contractor overcharges.**

**Impact: VA will recover over $4 million, with the potential for significant additional FY 1997 recoveries.**

As a result of VA team efforts during the period, the VA will recover $4 million in contract overcharges on several Federal Supply Schedule (FSS) contracts. In addition, we have work in process on several additional significant recoveries. Recoveries from contractors represent the collective efforts of the Office of Acquisition and Materiel Management, the Office of General Counsel (OGC), VHA, and the OIG working as a team to produce these results.

- Four FSS pharmaceutical companies agreed to remit $1.66 million to VA for contract overcharges. The OIG contract reviews disclosed that the four companies had failed to disclose accurate, current, and complete pricing data, during contract negotiations, to the National Acquisition Center contracting officer. One of the four companies had also violated the price reduction clause for its contract.

- Three pharmaceutical companies with FSS contracts acknowledged errors in calculating Federal Ceiling Prices under Public Law 102-585, and agreed to pay a total of $782,327 to VA for contract overcharges. We identified these errors during our reviews for Public Law compliance. Based on the results of one of the reviews, the contracting officer was able to negotiate lower FSS prices resulting in projected savings for 1997 of $213,735. The three companies also agreed to review their existing policies and procedures and identify necessary changes to incorporate adequate internal controls and correct the errors.

- An FSS medical equipment contractor proposed a voluntary refund of $411,864 for overcharges on three FSS contracts. We reviewed the contractor’s refund methodology, determined that certain review assumptions were not supported by contract documentation, and computed additional monies due. The contractor repaid $831,907 in contract overcharges.

- As a result of an OIG review, a medical supply company agreed to pay VA $709,000, which represents pricing adjustments on an FSS contract.

**Issue: Contractor Overpricing on Utility Services' Proposal**

**Conclusion: VA fixed costs for chilled water were overpriced.**

**Impact: $835,730 potential Better Use of Funds.**

We reviewed a contractor's proposal for a 35-year contract, with proposed costs of approximately $17.4 million, to provide chilled water for air conditioning at a VAMC. The proposal was submitted by an affiliated health care provider under an exchange of use agreement with the VAMC. The agreement provided that VA would furnish the equipment and the contractor would construct and maintain a chilled water plant and operate the plant. Our review determined that the proposal was overpriced due to excessive fixed costs and we recommended that the contracting officer negotiate a reduced price. The contracting officer agreed with the recommendation and was able to negotiate reduced costs, projected to be $835,730 over the life of the contract.

## 2. RECOVERY ON SHARING AGREEMENT

**Issue: VAMC Sharing Agreement with Medical School**

**Conclusion: VAMC was not paid for medical services provided.**

**Impact: VA recovered approximately $1.4 million.**

A prior audit of a sharing agreement at a VAMC resulted in an OGC opinion that the affiliated medical school was legally obligated to pay VA for medical services provided to it from 1985 until 1990, which had not already been paid for by Medicare or the medical school. The medical school disputed the decision. During this reporting period, the case was settled for $850,000, and together with sums previously collected, VA recovered approximately $1.4 million.

## 3. EXCESS EQUIPMENT PROGRAM

**Issue: VA's Excess Equipment Program**

**Conclusion: VA can enhance the financial benefits, controls, and reporting associated with its excess equipment program.**

**Impact: $5 million potential Better Use of Funds.**

We conducted an audit to assess the efficiency and effectiveness of VA's disposal of excess and surplus personal property at the request of the Office of Acquisition and Materiel Management. For FY 1995, VA reported to the General Services Administration (GSA) that

personal property originally costing $82 million had been determined to be excess to program needs and had been transferred directly to other federal agencies, scrapped, abandoned, destroyed, or sold. VA also reported that personal property originally costing $49 million had been traded-in or sold pending replacement with like items. Proceeds from VA sale of this property in FY 1995 totaled less than $6 million with an additional $4.5 million in sales by GSA and $3.4 million in trade-in allowances.

We concluded that the excess equipment program can be more effectively managed by: (i) ensuring that guidance is provided to facilities so that proceeds from the sale or exchange of unneeded equipment are retained for use by the Department, (ii) strengthening controls over the receipt and disposition of funds from the sale of personal property, and (iii) establishing a more accurate reporting system that reflects the results of property disposal activities. Appropriate retention of sale proceeds could provide facilities with additional funds that could be used to help support program operations. In FY 1995, facility direct sales of excess, unneeded, and worn-out equipment generated approximately $5 million in revenue which could have been retained by VA, but instead was deposited to non-VA miscellaneous receipts accounts with the U. S. Treasury. The Deputy Assistant Secretary for Acquisition and Materiel Management indicated agreement with the report recommendations and provided appropriate implementation actions. We consider all issues resolved. *(Audit of VA's Excess Equipment Program)*

## 4. PROCUREMENT FRAUD

**Issue: Integrity of the Procurement Program**

**Conclusion: Investigations disclosed third party fraud in VA's procurement program.**

**Impact: Assurance of integrity of Government program.**

- A former administrator for a major university system in southern California was sentenced in U.S. District Court to 33 months' imprisonment, 2 years' probation, and was ordered to make restitution of $300,000 to the Government. The sentence was the result of an extensive 2-year investigation which disclosed that the former administrator formulated a scheme to submit fraudulent invoices to the university for payment to two corporations which he created. The payments were for radiological services allegedly provided to veterans under a contract between the university and an affiliated VAMC. The companies were improperly paid over $1.75 million from VA contract funds over a 4-year period. To date, four criminal convictions have resulted from this investigation. Two firms and seven individuals involved in the case have been proposed for debarment.

- The owner of a firm which supplied tools and landscaping services to the Government was sentenced in U.S. District Court to 12 months in prison and 3 years' supervised probation after previously pleading guilty to conspiracy and mail fraud charges. An investigation revealed that the firm's owner and her husband conspired to pay bribes to VA officials to influence the awarding of Government contracts. In return for paying bribes, they received approximately 190 contracts at VAMCs in the Northeastern United States. The contracts were for the furnishing of hand tools, machine tools, and landscaping supplies and services. As a part of the same investigation, an employee of the maintenance and repair division at a VAMC pleaded guilty to conspiracy to commit bribery, after the investigation revealed that the employee had accepted bribes from the contractor who was awarded Department of Defense and VA contracts to supply small tools and equipment to Government facilities. The VA employee admitted to charges that he accepted cash and other items of value for awarding in excess of $18,000 in VA contracts to companies owned by the contractor. Sentencing of the employee is pending.

- A Florida corporation pleaded guilty to one count of submitting a false claim to VA. Investigation disclosed that the president of the corporation fraudulently overbilled a VAMC for medical and administrative transcription services performed by the corporation. The invoices submitted were inflated by at least 25 percent. The president of the corporation has agreed to pay VA $100,000 in restitution.

- The president and owner of a now defunct ambulance service company was indicted by a Federal grand jury on 20 counts of mail fraud. The indictment was the result of an investigation which revealed that the company president submitted false billings for services not rendered to various Governmental agencies, including VA, over a 3-year period. Total losses to the Government were in excess of $2 million.

- A subcontractor for the home oxygen program at a VAMC entered into a civil settlement with the Department of Justice and agreed to make restitution of $42,000 to the Government. An investigation disclosed that the vendor had overbilled VA for liquid oxygen tank refills. Approximately $11,000 of the restitution amount will be returned to the medical center.

# CONSTRUCTION PROGRAMS

## 1. ALLEGED INAPPROPRIATE CONSTRUCTION PROGRAM ACTION

**Issue: Alleged Management Errors Related to a New VA Regional Office Construction Project**

**Conclusion: The contracting officer acted within his authority, although a less expensive system than funded was accepted.**

**Impact: Resolution improved VA outcome, including $100,000 credit to VA.**

We reviewed allegations that VA had improperly accepted an alternate, deficient skylight system as part of the construction of a VA regional office, when VA already had funded a more expensive state-of-the-art skylight. Congress, on behalf of a constituent, forwarded the allegations to us for review. Our review showed that the VA contracting officer acted within his authority in accepting the alternate skylight system, and allowing deviations to the specifications for credit. However, we also concluded VA had accepted a significantly less expensive skylight than funded, that the skylight did not meet additional specifications, and the consideration VA received was not commensurate with the value of the deviations allowed. As a result of the complaint and OIG's involvement in the issue, the outcome for VA was improved significantly over what it would have been otherwise. Although VA ended up accepting an alternate skylight, VA obtained an additional $100,000 credit, a significantly improved warranty, and a continued waiver of delay claims by the general contractor. (*Results of Review of Congressional Inquiries Concerning Regional Office Skylight System Bay Pines, FL)*

## 2. FACILITIES CONSTRUCTION AND RENOVATION FRAUD

**Issue: Suspected Construction and Renovation Fraud**

**Conclusion: Individual sentenced for submitting false affidavits.**

**Impact: Individual is held accountable for illegal acts.**

A former senior underwriter for a firm which provided personal surety bonds for Federal projects was sentenced in U.S. District Court to 200 hours of community service and 36 months' probation. An investigation revealed that the underwriter prepared false affidavits of surety and submitted them as bonding on VA and U.S. Army construction projects.

# FINANCIAL MANAGEMENT

## VA'S FINANCIAL STATEMENTS

**Issue: VA's Consolidated Financial Statements for 1996 and 1995**

**Conclusion: Significant progress has been made to improve financial management in the Department, some reportable conditions remain.**

**Impact: Accurate reporting of financial information.**

We audited the Department's Consolidated Financial Statements for FYs 1996 and 1995. For FY 1996, VA reported assets totaling $43.4 billion and expenses totaling $43.9 billion. Audit results showed significant continued progress overall in improving financial management during the year. We provided an unqualified opinion on the September 30, 1996 year-end balances contained in VA's Statement of Financial Position (i.e., balance sheet). This is significant because it provides sound baseline information for the future. However, we also found that the FY 1995 year end balances and the FY 1996 statements of operations and changes in net position, cash flows, reconciliation of excess (shortage) of revenues and financing sources over total expenses, and budgetary resources and actual expenses remain qualified to the extent prior property and receivable errors affect the statements. The report also discusses six reportable internal control weaknesses that expose VA to significant risks and vulnerabilities if not addressed. VA management needs to:

- Ensure accurate reporting of real property, plant, and equipment, and related depreciation account balances by completing implementation of our prior recommendations.

- Ensure accurate reporting of net receivables and related revenue account balances by completing implementation of our prior recommendations.

- Increase the effectiveness of reviews of open unliquidated obligations.

- Continue efforts to correct overall system weaknesses caused by the antiquated computer system in VA's Life Insurance Programs.

- Improve automatic data processing security access controls.

- Strengthen Housing Credit Assistance Program accounting.

We reaffirmed the recommendations in our prior reports for previously reported items where improvements are in process, and made new recommendations to improve automatic data processing security access

controls and to strengthen Housing Credit Assistance Program accounting.

Additionally, the report discusses one previously reported significant nonconformance with the Public Law 96-466 requirement to charge interest and administrative costs on compensation and pension accounts receivable balances. VA needs to implement the law or work with Congress to change the law if the law is not considered appropriate.

The Assistant Secretary for Management (the Department's Chief Financial Officer) stated he shared the audit results with the financial managers in VHA, VBA, and National Cemetery Service, and other interested VA staff and program managers. They indicated general agreement with the audit results and plan to provide implementation plans on their respective areas. We will follow up on the implementation actions during our audit of VA's FY 1997 Consolidated Financial Statements. *(Audit of Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 1996 and 1995)*

**Issue: VBA'S FY 1996 Financial Statements**

**Conclusion: Addition action is needed to improve financial management of benefits.**

**Impact: Improved VBA financial management.**

As part of our audit of FY 1996 Consolidated Financial Statements, we tested VBA's C&P and education programs' account balances, selected transactions that affect the Consolidated Financial Statements, internal controls, and compliance with laws and VA regulations. Based on the audit test performed at VA's Hines Finance Center (HFC), Debt Management Center (DMC), and selected VAROs, we concluded that VBA staff generally established required internal controls for monitoring financial information, and generally complied with VA policies and procedures. However, additional actions were needed to correct or improve three conditions at the HFC, three other conditions at VA regional offices, and two other conditions at the DMC reported in prior audits. None of the issues materially affected the financial statements. We will follow-up during subsequent financial statement audits. *(Management Letter -- Fiscal Year 1996 Financial Statements-Benefits Programs)*

**Issue: Supply Fund Financial Statements**

**Conclusion: Management was correcting a number of system and control problems; however, other actions are needed to strengthen controls and improve financial management.**

**Impact: Financial statement opinion could not be provided pending implementation actions.**

We were requested by the Office of Acquisition and Materiel Management to audit VA's Supply Fund Statement of Financial Position as of September 30, 1995. We found that management was correcting a number of system and control problems, and we identified other actions which could be taken to strengthen internal controls and improve financial management. We disclaimed expressing an opinion on the financial statements until these improvements are in place, and sufficient, competent evidence is available to support the accounts with material balances.

The Assistant Secretary for Management outlined actions to strengthen the Supply Fund's internal control structure pertaining to accounting adjustments, accounts receivable, accounts payable, equipment, supply inventories, and cash. He also indicated that some of the actions recommended had already been addressed and that a strategy was being developed to address other shortcomings and implement needed improvements. The actions taken and planned are considered significant and should strengthen internal controls and improve financial management. *(Veterans Affairs Supply Fund Statement of Financial Position as of September 30, 1995)*

**Issue: VAMC Financial Statements**

**Conclusion: The VAMC was not in compliance with government purchase card procedures.**

**Impact: Advisory report.**

As part of the Department's FY 1996 Consolidated Financial Statement audit, we reviewed selected financial operations and tested internal controls as they related to expenditures at one VAMC. The review included a review of controls over the use and administration of government purchase cards.

We concluded that internal controls were adequate to ensure the reliability of obligations as shown in the financial statements as of September 30, 1996. However, we identified a number of instances of noncompliance with government purchase card practices and guidelines in a number of areas, including cardholder accountability, maintenance of cardholder accounts, certification and documentation of cardholder statements, use of required sources of supplies and services, and proper use of funds and distribution of costs. We did

not make any recommendations and issued an advisory report detailing our findings, with followup planned during future financial statement audits. *(Advisory - Greater Compliance with Governmentwide Purchase Card Procedures is Needed)*

# INFORMATION RESOURCES MANAGEMENT

## 1. SYSTEM DEVELOPMENT REVIEW

**Issue: Assessment of PAY-VA**

**Conclusion: Recommendations were made to assist with PAY-VA implementation.**

**Impact: Early review improved process to implement PAY-VA.**

The purpose of the evaluation was to provide an early assessment of the design, development, and implementation process for "PAY-VA", VA's new payroll system. This information technology initiative is estimated to have life-cycle costs of approximately $115 million. System operating benefits are estimated at about $205 million, primarily attributable to staffing reductions that will be achieved by consolidating support services, eliminating redundant service delivery functions, and fully leveraging technology.

We concluded that project managers had established management controls over the multi-faceted details this system development effort entails, and user involvement was significant. We identified opportunities to enhance PAY-VA implementation efforts concerning project documentation and workplans, cost information, contract deliverables, system security, correction of identified materiel weaknesses, training, and Contracting Officer's Technical Representative duties. The Assistant Secretary for Management and the Assistant Secretary for Human Resources and Administration agreed with the report recommendations, provided responsive implementation plans, and noted that our early review will be helpful in ensuring the success of the initiative. *(Evaluation of the Design and Implementation of PAY-VA)*

## 2. APPLICATION AND DATA SECURITY

**Issue: Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement (IFCAP) System, Phase III**

**Conclusion: IFCAP was performing as designed with the exception of application and data security.**

**Impact: Identification of significant problems which increase the vulnerability of the system to unauthorized access.**

IFCAP, an automated system supporting a variety of administrative activities, is used in the management and tracking of most of the $17 billion in VA funds allocated to medical care. We contracted for this audit to determine whether: (i) IFCAP, as installed at selected VHA

sites, is performing as designed; (ii) security procedures are adequate to prevent inappropriate use, destruction, disclosure, or modification of the system and/or data within it; (iii) backup procedures are adequate to allow manual processing during any downtime and permit complete recovery and updating of appropriate system files upon return of the system; and (iv) assess whether installation of site modifications interfere with system requirements and/or controls.

The audit found that the IFCAP system is performing as designed, with some exceptions, and that site-installed software modifications do not adversely affect internal controls. However, significant problems exist with the security procedures controlling access to the IFCAP system and data within it, and with backup and recovery procedures. In addition, application maintenance procedures employed at many of the sites visited increase the vulnerability of the system to access and modification without management's approval.

The Assistant Secretary for Management concurred with all recommendations. The Under Secretary for Health concurred with all but one recommendation, pending the results of an assessment by his management and development teams. Corrective actions were completed or implementation plans were provided for all other recommendations. We consider all issues resolved. *(Audit of IFCAP System, Phase III)*

# EMPLOYEE INTEGRITY AND OTHER ISSUES

## 1. SPECIALIZED INVESTIGATIONS

**Issue: Specialized Investigations Regional Task Force (SIRTF) Investigations**

**Conclusion: SIRTF investigations continue to disclose drug diversion, sales of controlled substances, workers' compensation fraud, and corruption.**

**Impact: Individuals are held accountable for illegal acts.**

The SIRTF is an enforcement unit comprised of special agents from the VA OIG and the VHA. Under the direct control of the VA OIG, SIRTF became operational in the spring of 1994 and has successfully investigated allegations of drug diversion; sales of controlled substances; sales and possession of firearms; workers' compensation fraud; and other criminal violations at VAMCs in the New York Metropolitan Area.

SIRTF was created in response to concerns voiced by the directors of three New York area medical centers over various criminal activities at their facilities. The VA OIG's assistance was sought because outside law enforcement agencies frequently were unable to lend assistance. Federal agencies such as the Drug Enforcement Administration and the Federal Bureau of Investigation have workloads and priorities which often preclude addressing criminal activity at VAMCs; the VAMC Security Police lacked the personnel and expertise to conduct these investigations; and local authorities were unable or unwilling to devote limited resources to what they perceived as a Federal problem.

During the reporting period, the results of SIRTF investigations were in three major areas: drug diversion and sales of controlled substances, workers' compensation fraud, and corruption. The following are examples of investigations.

**Controlled Substances**

- A former VAMC outpatient was sentenced in U. S. District Court to 7 months' imprisonment, to be followed by 3 years' probation. An investigation disclosed that he sold methadone (a Schedule II controlled substance) to an undercover agent. Another outpatient was sentenced to 3 months' imprisonment, followed by 3 years' supervised release for illegally distributing methadone.

- Another former VAMC outpatient was sentenced in U.S. District Court to 21 months' imprisonment and 3 years' probation. He previously

pleaded guilty to possession with intent to distribute methadone. The outpatient sold methadone to an undercover agent during an investigation of drug diversion at the VAMC.

- An investigation of the diversion and sale of VA pharmaceuticals at a VAMC resulted in the sentencing of four individuals in U.S. District Court. One individual was sentenced to 15 months' imprisonment and 3 years' probation. The second was sentenced to 3 months' imprisonment and 3 years' probation. Two others each were sentenced to 3 years' probation. All of the subjects had pleaded guilty to charges of possession with intent to distribute methadone and the distribution of methadone on VAMC grounds.

- An individual was sentenced in U.S. District Court to 7 months' imprisonment, to be followed by deportation to the Dominican Republic. The individual previously pleaded guilty to possession with the intent to distribute controlled substances and the distribution of controlled substances, some of which had been diverted from a VAMC.

- An environmental management services employee and a former volunteer at a VAMC were indicted in U.S. District Court for possession with intent to distribute, and distribution of, controlled substances. These individuals previously were arrested by special agents of the VA OIG and the Drug Enforcement Administration. Both individuals had sold cocaine and heroin to a SIRTF undercover agent on the grounds of the VAMC.

- An individual pleaded guilty in U.S. District Court to the illegal sale of controlled substances and making false statements to the Government. During an investigation of drug diversion, the individual sold 240 Percocet tablets to an undercover agent. The investigation also revealed that the individual sold diverted VA pharmaceuticals and was in receipt of VA pension benefits to which he was not entitled.

- A former volunteer at a VAMC was sentenced in U.S. District Court to 5 months' incarceration, 5 months' home detention, and 3 years' probation. He previously had pleaded guilty to possession with intent to distribute marijuana and cocaine. The individual had sold these drugs to a SIRTF undercover agent. These sales took place at a parking lot located within 1,000 feet of a VAMC Day Care/Nursery Center.

**Workers' Compensation Fraud**

- The chief of labor relations at a VAMC pleaded guilty to conspiracy to commit workers' compensation fraud. The SIRTF investigation disclosed that the individual conspired with her husband, a VA food services employee, to defraud the U.S. Government by assisting in

the preparation and submission of workers' compensation documents which failed to report earnings of a business which they owned. The husband, who had pleaded guilty previously, had established a limousine service in which he served as the owner, operator, and driver while receiving $122,000 in workers' compensation payments for an alleged injury to his lower back. He was sentenced to 1 month in prison, 2 years' supervised release (including 6 months' home detention), and ordered to pay $40,000 in restitution. Estimated cost savings to the VA as a result of his conviction and termination from this program is approximately $540,000.

- A former VAMC food service employee pleaded guilty in U.S. District Court to one count of workers' compensation fraud. During 1992, the employee claimed to have injured his lower back while removing rubbish and subsequently received $29,049 in workers' compensation benefits. An investigation conducted by SIRTF revealed that he was employed as a home care attendant while receiving these benefits and had reported no income to the Department of Labor. In addition, the investigation revealed that he previously had been convicted by New York State for workers' compensation fraud. The estimated savings to the Government as a result of the conviction and termination from the program is approximately $374,000.

- A VAMC electrician foreman pleaded guilty in U.S. District Court to one count of making false statements to the Government. Investigation disclosed that the electrician collected approximately $200,000 in workers' compensation payments for an alleged stress injury while he was self-employed as an electrician for up to 10 hours per day. He faces criminal and civil penalties totaling approximately $600,000. The estimated cost savings to the VA as a result of his conviction and termination from this program is approximately $360,000.

- A former VA licensed practical nurse was sentenced in U.S. District Court to 5 years' probation and ordered to file delinquent Federal income tax returns. She previously pleaded guilty to one count of workers' compensation benefits fraud. An investigation by the SIRTF disclosed that the nurse had collected $210,000 in workers' compensation benefits during a period when she was employed with six different nursing services. Her termination from the workers' compensation program will result in a cost savings to VA of approximately $300,000.

- A former VAMC employee was indicted in U.S. District Court on three counts of making false statements to the Government. An investigation determined that the employee, who had certified to the Department of Labor that he had not been employed since his receipt of over $79,000 in workers' compensation benefits, was the owner and operator of a restaurant. Evidence collected during the investigation included videotaping the employee in the operation of his business. His termination from the workers' compensation

program will result in a cost savings to VA of approximately $200,000.

**Corruption**

- A VA police officer pleaded guilty in U.S. District Court to bribery of a public official. An investigation disclosed that the police officer accepted money and things of value from a SIRTF undercover agent in return for allowing individuals to sell illegal narcotics inside the VAMC.

## 2. EMPLOYEE AND THIRD-PARTY INTEGRITY

**Issue: Investigations of Misconduct and/or Illegal Acts by Employees and Third Parties**

**Conclusion: Instances of thief, embezzlement, bribery, fraud, conflict of interest, and other acts of misconduct were disclosed.**

**Impact: Individuals are held accountable for illegal acts.**

**Employee Theft/Use/Sale of Illegal Drugs**

- An employee of a VAMC was terminated from his position because of illegal drug activity while on VA property. This was a joint investigation involving the VA OIG and the Maryland State Police. The employee had sold cocaine to an OIG source on several occasions.

**Theft and Embezzlement**

- A former employee of a VA supply depot was sentenced in U.S. District Court to 6 months' home confinement, 5 years' probation and ordered to pay restitution to the Government in the amount of $6,000. An investigation disclosed that the former employee used her Government position to generate and mail five U.S. Treasury checks to non-existent vendors. The funds then were deposited into bank accounts using false identities and subsequently distributed to the employee and two co-conspirators. Loss to VA exceeded $88,000.

- A Federal grand jury indicted a former VA Insurance Center claims examiner for theft of Government funds and money laundering. An investigation disclosed that the claims examiner fraudulently generated insurance awards totaling about $58,300 and diverted the checks to the home addresses of two accomplices. Subsequently, the accomplices either cashed or attempted to cash the VA insurance checks, sharing the proceeds with the claims examiner.

- A psychiatric nursing assistant at a VAMC was sentenced in U.S. District Court to 6 months' home confinement, 3 years' probation,

and ordered to pay $7,200 in restitution to VA. He previously pleaded guilty to six counts of theft of Government funds. Investigation disclosed that the nursing assistant was in receipt of VA pension benefits, awarded based on lack of income, while he was employed at the medical center. In order to perpetrate this fraud, he failed to report his employment to the local VA regional office, certifying he was unemployed. Loss to the Government was $28,186.

- A former staff nurse in the Nursing Home Care Unit of a VAMC was sentenced in U.S. District Court to 5 years' probation, ordered to perform 250 hours of community service, and to make restitution in the amount of $87,752. She previously pleaded guilty to one count of bank fraud. An investigation revealed that she had misappropriated the funds from the bank account of a veteran patient.

- A VAMC physician was sentenced in U.S. District Court to 3 years' probation, ordered to pay $77,623 in restitution, and to relinquish millions of airline frequent flier miles. An investigation disclosed a scheme in which the physician would purchase hundreds of airline tickets using credit cards and then obtain refunds and credits in excess of the original amount paid.

**Acceptance of Bribes, Kickbacks, Gratuities, Conflicts of Interest**

- Two former VAMC employees and a medical equipment vendor were indicted by a Federal grand jury in a nine-count indictment charging bribery, theft of Government property, conspiracy and money laundering. An investigation disclosed that the vendor provided kickbacks to the employees in exchange for ordering equipment for VA at inflated prices. The employees also misappropriated other VA property for personal use.

- A former veterans benefits counselor pleaded guilty in U.S. District Court to three counts of soliciting bribes by a public official and one count of tampering with a Federal witness. An investigation disclosed that the former employee solicited and accepted multiple payments from the widows of deceased veterans in return for expediting the processing of their claims for VA benefits.

**Workers' Compensation Fraud**

- A former VAMC records clerk was sentenced in U.S. District Court to 2 months' home confinement and 3 years' probation. She previously pleaded guilty to making a false workers' compensation claim. An investigation disclosed that the clerk fraudulently obtained over $60,000 in workers' compensation benefits, while periodically employed. Future savings to VA due to her removal from the compensation rolls are estimated at $236,000.

- A former VAMC nurse was indicted by a Federal grand jury on 15 counts of making false statements to the Government in connection with the workers' compensation program. The indictment charged that the former nurse made the false statements in order to conceal her full-time employment while drawing over $22,000 in workers' compensation benefits based on an on-the-job injury at the VAMC. The former nurse had at least five different jobs while in receipt of the benefits. Her termination from the workers' compensation program will result in a cost savings to VA of approximately $50,000.

- A former VAMC cardiologist who received over $350,000 in workers' compensation disability benefits over 7 years was given notice of termination of his benefits. An investigation revealed that the physician was awarded workers' compensation benefits during August 1989 as a result of stress brought on by his VA employment, yet he continued to work at the medical center while on workers' compensation in order to retain his accreditation. Projected savings from his termination from the program exceed $700,000.

**Destruction of Government Property**

- Two individuals were sentenced in U.S. District Court for intentionally desecrating veterans' graves and mutilating the U.S. Flag flying over the grounds of a national cemetery. Each individual was sentenced to 3 years' probation. One of the individuals also was ordered confined to a Bureau of Prisons halfway house for a period of 6 months.

**Employee Misconduct**

- The former director of a VA facility pleaded guilty in U.S. District Court to one count of possession of materials depicting minors engaged in sexually explicit conduct. An investigation revealed that while employed as the director, he utilized his VA computer to download and store sexually explicit pictures of minors. He faces a maximum penalty of 5 years in prison and a $250,000 fine upon sentencing.

- A former VA police officer was sentenced in U.S. District Court to 6 months' home detention, 4 years' probation, 100 hours of community service and $4,000 in restitution to VA. The former officer previously had pleaded guilty to two counts of theft of Government property. An investigation revealed that the former officer was stealing Government property from the medical center and selling it for a fraction of its value.

- The chief of surgical service of a VAMC resigned from his position following an investigation which disclosed that he had subordinates modify surgical records to show that he was performing surgery. He used the altered reports as supporting documentation to obtain and

retain surgical privileges at the VAMC. The investigation disclosed that an employee, at the doctor's direction, used the doctor's computer access code to make changes to surgical records in the VAMC's Decentralized Hospital Computer Program after the date of surgery. Interviews conducted during the investigation indicated that personnel employed at the medical center for as long as 20 years never saw the chief make a surgical incision or act as a surgeon or first assistant to surgery.

**Issue: Congressionally Requested Reviews of Employee Travel Issues**

**Conclusion: Applicable regulations and policy guidance were met.**

**Impact: Assurance of integrity of Government requirements.**

- At the request of a Member of Congress, we reviewed the travel of the Secretary, Department of Veterans Affairs to Northern California in October 1996 and assessed compliance with applicable requirements. We concluded that the requirements and policy guidance for political activities and related travel were met, and an appropriate distribution was made for the travel costs allocable between appropriated funds and campaign funds. No recommendations were made. The Office of the Secretary concurred with our conclusions. *(Review of Secretary's Travel Between October 5 & 18, 1996)*

- At the request of a Member of Congress, we reviewed the Department's policies, procedures, and practices regarding political and official travel, to determine whether applicable regulations and policy guidance were met. We concluded that VA's policies and procedures in place were adequate, and the requirements and policy guidance for political activities and related travel were met. As we found adherence to regulatory and policy guidance, and found the procedures to be adequate, no recommendations were made. The Office of the Secretary reviewed the draft report and concurred with the facts. *(Audit of the Department's Use of Political Versus Official Travel)*

**Issue: Special Inquiries of Alleged Employee Misconduct or Mismanagement**

**Conclusion: Several alleged conditions were substantiated, but willful misconduct or mismanagement as a cause was rarely disclosed.**

**Impact: Seven VA employees received or will receive disciplinary action; $90,000 potential Better Use of Funds; and $5,000 recovery.**

During the period, we issued 20 special inquiry reports. Following are summations of 8 of the more significant reports issued:

- Our review of sexual harassment allegations concluded that a senior official sexually harassed one female employee, and displayed abusive, threatening, and inappropriate behavior towards three female employees. Management reached a settlement with the senior official, which resulted in his moving from the Senior Executive Service to a General Schedule position at another facility.

- We reviewed allegations that a senior management official mismanaged the construction and renovation of a nursing home care unit (NHCU) and the related activation funding. We determined that management spent $2.1 million for construction, renovation, and activation of the NHCU, but, when completed, used the area as "swing space" for specialty clinics undergoing renovation instead of an NHCU. Veterans seeking nursing home care had been placed in contract facilities or other VA facilities. Management had also paid a consultant over $90,000 in FY 1996, to work 4 days per month. After starting our review and discussing the NHCU issue with the applicable Veterans Integrated Service Network (VISN), plans were initiated to activate the NHCU with the funding previously provided. The VISN also evaluated the need for the consultant contract and requested its termination.

- Another special inquiry concluded that two mid-level managers at a VAMC reprised against an employee for whistleblowing to the OIG. Both mid-level managers were removed from their supervisory duties and were counseled for their actions. One of the employees retired from the Federal government.

- We found that a senior management official spent $201,000 which was $79,000 more than VHA policy allowed for the interior renovation of his residence, a VA-owned property. He also failed to get timely reappraisals of VA quarters and extended rent adjustments without appropriate authority to do so. The effect of these actions was that for several years, VA employees occupying the quarters paid less rent than they should have. We also found VHA quarters management policies needed updating to reflect the latest guidance from the Office of Management and Budget. In

response to our report, VHA management initiated appropriate corrective actions, including necessary policy revisions.

- An inquiry at another VAMC found that four VAMC employees received supplements to their VA salaries from an affiliated university in violation of Federal law, although they believed they were performing and being paid for non-VA duties. Management took appropriate action to ensure the supplements were terminated, implemented safeguards at the VAMC to avoid repetition of the improper supplements, and requested the affiliated university to also establish such safeguards.

- Another special inquiry disclosed that a manager had incorrectly certified one of his employee's time and attendance records as working full-time, although he knew the employee was only working part-time hours. The manager received a written admonishment for his actions, and collection procedures were initiated to recover $5,078. The employee fully reimbursed the VA for the unearned salary.

- Another special inquiry concluded that a senior management official inappropriately initiated a procurement for interior design services from a former employee. In addition, a procurement official improperly approved a noncompetitive award for personal services, in violation of procurement regulations. Both individuals received counseling.

- We reviewed several allegations of mismanagement and irregularities at a VAMC. We found that a service chief had violated time and attendance regulations by taking unauthorized absences from the VAMC during his official tour of duty and we recommended appropriate administrative action against the chief. The other issues related to areas in which management controls were not adequate or written policy was needed. Management completed, or planned to take, appropriate action to address our concerns.