Office of Inspector General

Semiannual Report to Congress

April 1, 2001 - September 30, 2001

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, 2001. The OIG is dedicated to help ensure that veterans and their families receive the care, support, and recognition they have earned through service to our country. This report is issued in accordance with the provisions of the Inspector General Act of 1978, as amended.

OIG oversight of major VA programs resulted in systemic improvements and increased efficiencies in areas of medical care, benefits administration, procurement, financial management, information technology, and facilities management. Overall, OIG audits, investigations, and other reviews identified $1.7 billion in monetary benefits, for an OIG return on investment of $64 for every dollar expended.

Our criminal investigations division continues to place a priority on safety and security at VA facilities by working closely with VA police on items of mutual concern. During this semiannual reporting period, we conducted over 85 joint investigative cases with the VA police and 39 individuals were arrested for crimes committed against VA or on VA property. All told, we concluded over 300 criminal cases and were involved in over 180 arrests. In addition, over $26 million has been returned or saved by VA as a result of our investigative efforts.

Following the terrorist attacks on September 11, 2001, we immediately provided criminal investigators to assist in the recovery of evidence and to pursue other investigative leads. We have also provided criminal investigators to support the Federal Air Marshall program.

Our audit oversight of VA, the second largest Department in the Federal Government, focused on determining how programs can work better, while improving service to veterans and their families. For example, an audit presented opportunities to better use $1.48 billion by including veterans classified as priority group 7 in the Veterans Health Administration's (VHA) resource allocation formula known as the Veterans Equitable Resource Allocation or VERA. Also, an audit of VA medical center (VAMC) management of engineering supply inventories presented opportunities to reduce engineering supplies by over 67 percent or $168 million. Monetary benefits of this type can be redirected to programs that can improve or increase services to veterans.

Our healthcare inspections focus on quality of care issues in VA, which operates the largest health care system in the United States. We visited a number of facilities this period to respond to Congressional and other special requests. We reviewed patient allegations pertaining to quality of care issues received by the OIG Hotline. Most notably, we oversaw VHA's responses to 177 inquiries sent to them for action and resolution. This involved reviewing 513 issues and assessing the appropriateness of 200 recommendations to improve the quality of care and services provided to patients.

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 and VA regional offices (VAROs) on a cyclical basis. The 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.

RICHARD J. GRIFFIN
Inspector General

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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, 2001. The following statistical data highlights OIG activities and accomplishments during the reporting period.

	Current 6 Months 4/1/01 – 9/30/01	FY 2001 10/1/00 – 9/30/01
	Dollars in Millions	
DOLLAR IMPACT		
Funds Put to Better Use	$1,664.7	$4,123.9
Dollar Recoveries	$6.8	$31.2
Fines, Penalties, Restitutions, and Civil Judgments	$17.4	$33.7
RETURN ON INVESTMENT		
Dollar Impact ($1,688.9) / Cost of OIG Operations ($26.2)	64 : 1	
Dollar Impact ($4,188.8) / Cost of OIG Operations ($48.5)		86 : 1
OTHER IMPACT		
Arrests	186	401
Indictments	175	376
Convictions	165	337
Administrative Sanctions	291	541
ACTIVITIES		
Reports Issued		
Combined Assessment Program	16	26
Audits	18	26
Contract Reviews	20	48
Healthcare Inspections	15	22
Administrative Investigations	9	14
Investigative Cases		
Opened	379	777
Closed	329	651
Healthcare Inspections Activities		
Oversight Reviews	162	284
Consultations	6	12
Technical Reviews	37	98
Hotline Activities		
Contacts	8,334	16,658
Cases Opened	650	1,179
Cases Closed	630	1,160

OFFICE OF INVESTIGATIONS

Overall Focus

This semiannual period the Office of Investigations achieved significant increases in the number of investigative cases initiated and concluded. During this period, the office concluded 329 investigations resulting in 340 judicial actions and over $26 million recovered or saved. Investigative activities resulted in the arrests of 186 individuals who had committed crimes involving VA programs and operations or on VA facilities. In addition, the office realized monetary benefits of over $11 returned to or saved by the Government for each $1 spent on our investigative activities. Emphasis was placed on safety and security at VA medical centers (VAMCs). Working hand-in-hand with VA police, we assisted in 39 arrests of individuals who committed crimes at VAMCs. During this semiannual period, many significant cases were investigated. Examples of these cases follow.

Veterans Health Administration

Five individuals were indicted on charges of wire fraud and false use of Social Security numbers. The charges were filed after a VA OIG investigation determined the individuals used the identifying data, including names, dates of birth, and Social Security numbers of VAMC patients to obtain cellular phone service and credit cards. This investigation is ongoing and to date 18 individuals have been identified as being involved in the scheme that includes the identity theft of over 50 veterans.

A former VAMC pharmacy employee was arrested on charges that he aided in an armed robbery of a VAMC pharmacy. The former employee, a co-op student, was charged with aiding and abetting a robbery in which controlled substances were taken. The former employee provided information and assistance to the individuals who carried out the robbery, which resulted in the theft of 3,000 tablets of OxyContin, as well as varying amounts of other narcotic drugs. Street value of the stolen drugs was estimated at over $250,000.

A former VA nurse pleaded guilty to charges of stealing and diverting various narcotics, and converting them to her own use. This investigation determined the nurse stole liquid morphine from syringes intended for patient use and replaced the drug with saline solution. In addition, on at least 21 occasions she falsified medical records by stating that she had administered various controlled substances to patients when in fact she had never administered the drugs and diverted them for her own use.

Veterans Benefits Administration

A VA employee and two former VA employees were arrested and charged with theft of Government property and conspiracy. An ongoing investigation has disclosed the individuals defrauded VA of approximately $11 million between 1993 and August 2001. The VA employee accessed and falsified numerous files to generate hundreds of benefit payments under the accounts of veterans who had died and had no beneficiaries. Subsequently, large retroactive benefits checks were disbursed or electronically deposited into accounts belonging to accomplices. Ten additional co-conspirators, who are not VA employees, have also been charged. The investigation continues.

The wife of a veteran was sentenced to 36 months' supervised probation and ordered to pay $101,874 restitution. She had previously pleaded guilty to one count of misprision of a felony in connection with her role in conspiring to fake her husband's death, and cover up her husband's identity. A joint investigation disclosed the woman conspired with her husband's family to enrich themselves by applying for and receiving VA and other Government benefits totaling over $300,000. The woman's husband was a U.S. Marine who faced charges of child molestation in a military court. He faked his own death in order to avoid those charges, but subsequently was apprehended and charged with additional molestation charges for which he received a sentence of 45 years' imprisonment.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for $1.66 Billion

Audits and evaluations were focused on operations and performance results to improve service to veterans. During this reporting period, 54 audits, evaluations, and reviews, including Combined Assessment Program (CAP) reviews, identified opportunities to save or make better use of $1.66 billion. The Office of Audit demonstrated a benefit to cost ratio of $150 for every dollar spent. Contract reviews returned $10 in monetary benefits for every dollar spent.

Veterans Health Administration

The following are examples of major health care related audits. Our audit examining the provision of health care services to veterans enrolled for medical care in Veterans Integrated Service Network (VISN) 8 found that the network was unable to provide veterans with timely access to some of its clinical services because of clinic overcrowding. The network's efforts to improve clinic timeliness and reduce overcrowding require the modification of the Veterans Health Administration (VHA) resource allocation strategy to include priority group 7 veterans in the Veterans Equitable Resource Allocation (VERA) funding distributions. This change would allow funding distributions for all networks to be based on the total number of veterans who receive care and would be more closely aligned with the patient enrollment system. Improved network monitoring of clinical resource utilization and equity of resource distributions among its facilities would help reduce clinic overcrowding and excessive patient waiting times due to increasing workload. Including priority group 7 veterans in the VERA resource allocation formula could result in more effective funding distributions for care of these veterans to all of VHA's 22 VISNs. This funding distribution is estimated to total $1.48 billion in fiscal year (FY) 2001. Our audit of VAMCs' engineering supply inventories found that VA could reduce large excess inventories by using automation, purchasing smaller quantities, and consolidating storage locations. We reported engineering inventories could be reduced by $168 million.

Office of Management

As part of the Consolidated Financial Statements audit, we issued six management letters addressing financial reporting and internal control issues. The letters provided Department managers additional automated data processing security observations and advice that will enable the Department to improve accounting operations and internal controls. None of the conditions noted had a material effect on the FY 2000 Consolidated Financial Statements, but correction of the conditions was considered necessary for effective operations.

Contract Review and Evaluation

During the period, we completed 20 contract reviews – 7 preaward and 13 postaward reviews. These reviews identified monetary benefits of $11.7 million resulting from contractor actual or potential overcharges to VA.

OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections (OHI) participated with the Offices of Audit and Investigations on 16 CAP reviews and reported on specific clinical issues warranting the attention of VA managers. OHI reviewed 115 health care related issues, and made 92 recommendations to improve clinical operations and activities and enhance the quality of care and services provided to patients.

Our inspectors visited a number of facilities this period to respond to Congressional and other special requests, and reviewed patient allegations pertaining to quality of care issues received by the OIG Hotline. OHI completed 15 Hotline cases, reviewed 38 issues, and developed 74 recommendations to correct conditions identified and improve the care and services provided to patients. Findings and recommendations resulted in managers taking action to issue new and revised procedures, administrative actions, resource realignments, and environmental and safety improvements. OHI also oversaw 162 Hotline inquiries sent to VHA for action and resolution. These cases involved 475 allegations which resulted in 126 recommendations for corrective action.

OFFICE OF MANAGEMENT AND ADMINISTRATION

Hotline

The Hotline 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 8,334 contacts. We opened 650 cases and closed 630 cases containing 181 substantiated allegations. Hotline staff responded to 104 inquiries received from members of the Senate and House of Representatives. The cases we opened led to 59 administrative sanctions against employees and 73 corrective actions taken by management to improve VA operations and activities. Examples of some of the issues addressed by Hotline include: (i) attending physicians who were not supervising residents; (ii) delays in responding to or transporting patients; (iii) employees who abused time and leave and violated ethical conduct standards; (iv) patient safety violations; (v) contracting irregularities; and (vi) instances of misconduct by VA employees.

Information Technology and Data Analysis

The OIG Data Analysis section provides automated data processing technical support to all elements of the OIG and other Government agencies needing information from VA automated systems. One of its main tasks is to develop proactive computer profiles that search VA computer data for patterns of inconsistent or irregular records with a high potential for fraud and in turn refer these leads to OIG auditors and investigators for further review. As an example, when fraud was first suspected at a VA Regional Office (VARO), the section quickly discovered approximately $11 million in suspicious benefits payments associated with this case.

During this period, the section completed 187 ad hoc requests for information and data submitted from all OIG operational elements. They also provided 67 proactive reports using data mining to detect potential fraud in VA systems and programs and completed 72 requests for auditors performing VA postaward and preaward contract reviews of private vendors under contract with the VA.

This section also works closely with other VA offices. As an example, they worked with auditors from the VA Office of Financial Policy, Financial and Systems Quality Assurance Service to test fraud detection computer profiles. This resulted in the Service's auditors referring 42 cases as potential fraud to OIG investigators with potential monetary recoveries of $1.8 million. The section also worked with the Veterans Benefits Administration (VBA) to form a collaborative effort to help identify internal and external fraud within compensation and pension computerized systems. Examples of this collaboration include providing VBA with the results of one-time payment reviews and a list of beneficiaries with no Social Security number or date of birth on the VBA computer record. As a result of the reviews, VBA is considering a mailing to beneficiaries to obtain a valid Social Security number and date of birth to repair each record. Also after raising the issue of the fraud vulnerability of returned benefit checks with VBA officials, the VBA Philadelphia Insurance Center was tasked to complete a study of returned mail. The section also worked with VBA representatives on data mining activities and how VBA could use it to detect fraud in their computer systems. Examples of these activities included providing copies of certain VBA files to the Data Management Office for testing and working with the Philadelphia Insurance Center on methods to detect internal fraud in VA's insurance systems.

Follow Up on OIG Reports

During the reporting period, action was taken to track implementation of OIG audits, inspections, and reviews with over $4.1 billion of actual or potential monetary benefits. Of this amount, $2.6 billion was resolved as VA officials agreed to implement OIG recommendations. The remaining $1.5 billion primarily relates to one audit report on which the Under Secretary for Health deferred concurrence or non-concurrence with the recommendation to include priority group 7 veterans in the VERA system until other options are considered. After obtaining information that VA officials had fully implemented corrective actions, 70 reports and 376 recommendations were closed.

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 documentation of the actions required to implement the reports in a reasonable period. However, we are concerned about four OIG reports related to VHA and VBA management that were issued in FY 1998 and earlier remain unimplemented. VHA has three reports (one report issued in each of FYs' 1994, 1996, and 1997), and VBA has one report issued in FY 1997. Details about these reports can be found beginning on page 65.

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.

VA Central Office
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 (Diversity Management and Equal Employment Opportunity, Human Resources Management, Administration, Security and Law Enforcement, and Resolution Management),

- Public and Intergovernmental Affairs, and
- Congressional and Legislative 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 Utilization, the Center for Minority Veterans, the Center for Women Veterans, and the Office of Employment Discrimination Complaint Adjudication.

Resources

While most Americans recognize the VA as a Government agency, few realize that it is the second largest Federal employer. For FY 2001, VA employed approximately 206,200 employees and had a $47.5 billion budget. There are an estimated 25 million living veterans. To serve our Nation's veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Philippines.

Approximately 188,000 of VA's employees work in VHA. Health care was funded at $20.6 billion, approximately 43 percent of VA's budget in FY 2001. VHA provided care to an average of 57,000 inpatients daily. During FY 2001, slightly more than 41 million episodes of care were estimated for outpatients. There are 172 hospitals, 781 outpatient clinics, 135 nursing home units, 206 Vietnam veterans centers, and 43 domiciliaries.

Veterans benefits were funded at $25 billion, almost 53 percent of VA's budget in FY 2001. Over 11,800 VBA employees provided benefits to veterans and their families. About 2.6 million veterans and their beneficiaries received compensation benefits valued at $20.4 billion. Also, over $3 billion in pension benefits are provided to veterans and survivors. VA life insurance programs had 4.5 million policies in force with a face value of over $596 billion.

Almost 250,000 home loans were guaranteed in FY 2001, with a value of almost $31.3 billion.

The National Cemetery Administration operated and maintained 119 cemeteries and employed over 1,400 staff in FY 2001. Operations of NCA and all of VA's burial benefits account for approximately $306 million of VA's budget. Interments in VA cemeteries continue to increase each year, with 86,100 estimated for FY 2001. Approximately 345,000 headstones and markers were 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

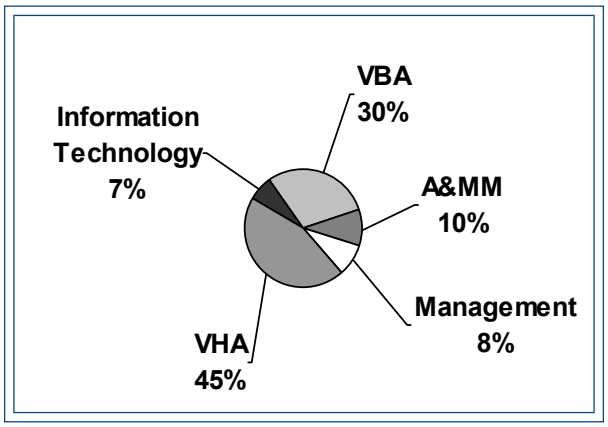
Allocated full time equivalent (FTE) employees for the FY 2001 staffing plan was as follows:

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

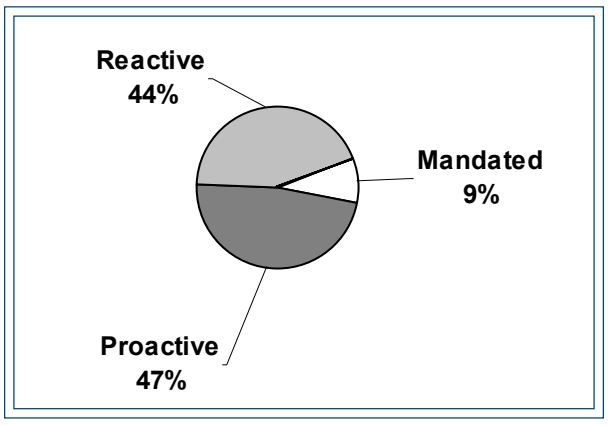
In addition, 24 FTE are reimbursed for a Department contract review function.

FY 2001 funding for OIG operations is $48.5 million, with $46.3 million from appropriations and $2.2 million through a reimbursable agreement. Approximately 75 percent of the total funding is for salaries and benefits, 5 percent for official travel, and the remaining 20 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 to VA's major organizational areas, are indicated in the following chart.



The following chart indicates the percent of OIG resources which have been applied 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, oversight of VHA's quality assurance programs and Office of the Medical Inspector, follow up activities on OIG reports, and releases of Freedom of Information Act information.

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 Office 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, home to the VA Office of Inspector General

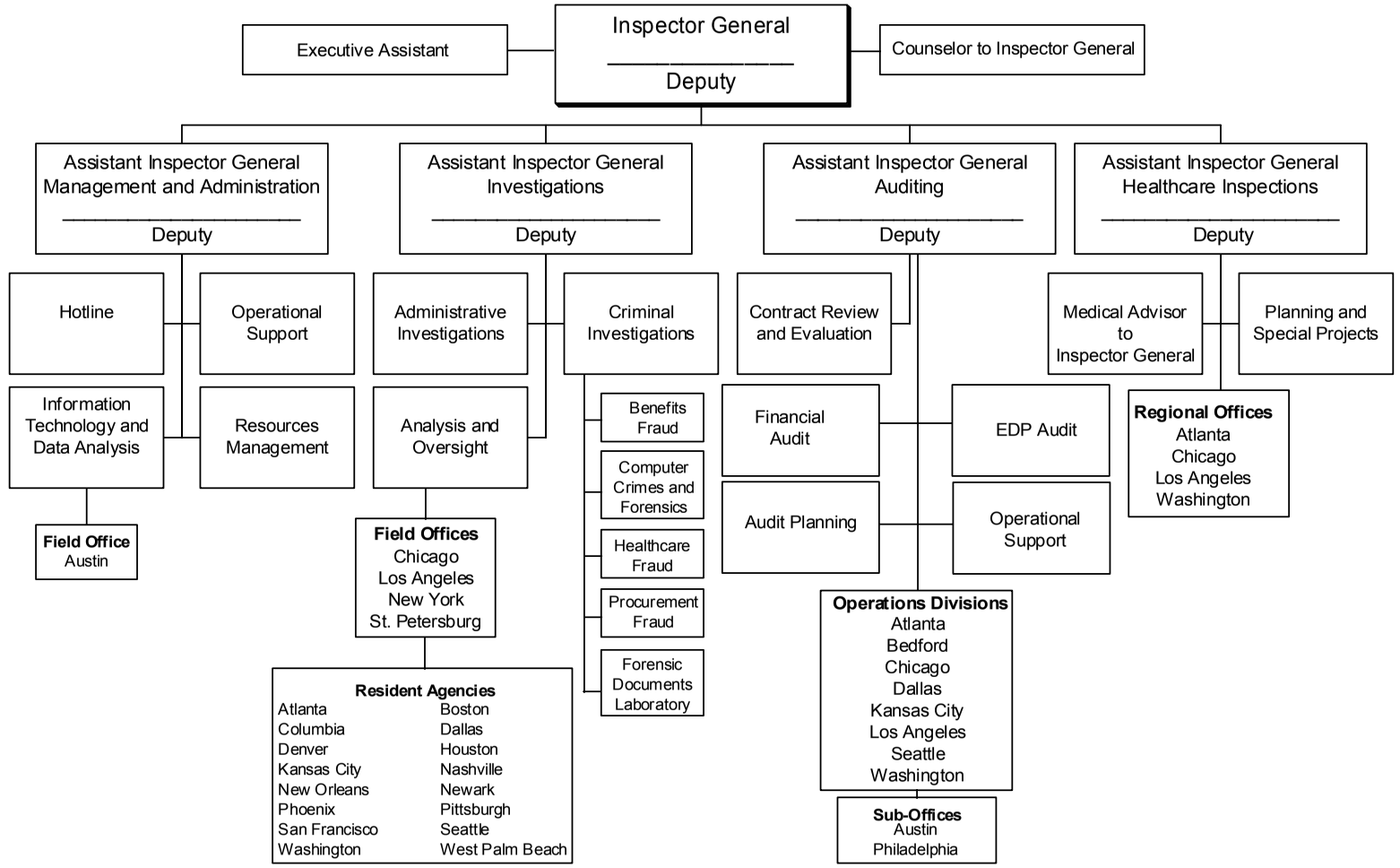
OIG Mission Statement

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. 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



COMBINED ASSESSMENT PROGRAM

Combined Assessment Program Overview - Medical

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. CAP reviews provide cyclical oversight of VAMC operations, focusing on the quality, efficiency, and effectiveness of service provided to veterans.

The CAP combines the skills and abilities of the OIG to provide collaborative assessments of VA medical facilities. The OIG team consists of representatives from the Offices of Healthcare Inspections, Audit, and Investigations. They provide an independent and objective assessment of key operations and programs at VAMCs on a 6-year recurring basis.

Healthcare inspectors conduct proactive reviews to evaluate care provided in VA health care facilities and assess the 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. Their effort includes the use of standardized survey instruments.

Auditors conduct reviews to ensure management controls are in place and operating 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 include patient management, credentialing and privileging, agent cashier activities, data integrity, and the Medical Care Cost Fund.

Special agents conduct fraud and integrity awareness briefings. The purpose of these briefings is to provide VAMC officials 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. The Office of Investigations conducted 88 fraud and integrity briefings for approximately 3,900 employees. Special agents also investigate certain matters referred to the OIG by VA employees, members of Congress, veterans, and others.

During the period April 1 through September 30, 2001, we issued 15 CAP reports for health care facilities. See Appendix A for the full title and issue date of the CAP reports issued this period. The reports relate to the following VA medical facilities:

- Southern Arizona VA Health Care System
- VA Northern California Health Care System
- VA Northern Indiana Health Care System (Fort Wayne and Marion)
- Richard L. Roudebush VA Medical Center Indianapolis, IN
- VA Central Iowa Health Care System (Des Moines and Knoxville)
- Harry S. Truman Memorial Veterans' Hospital Columbia, MO
- VA Medical Center Manchester, NH
- VA New Jersey Health Care System
- New Mexico VA Health Care System
- VA Medical Center Cincinnati, OH
- VA Medical Center Oklahoma City, OK
- Ralph H. Johnson VA Medical Center Charleston, SC
- Royal C. Johnson Memorial VA Medical and Regional Office Center Sioux Falls, SD
- VA Tennessee Valley Healthcare System
- South Texas Veterans Health Care System

Summary of Findings

Our reviews identified the following areas that required the attention of VHA management:

Financial and Administrative Management

- Information technology security was deficient in 13 of 15 (87 percent) facilities visited. VHA Directive 6210 states that controlled and restricted areas are to be protected and specifies procedures for protecting system resources from unauthorized access, disclosure, modifications, destruction and misuse.

- Controlled substances inspections or other controls were deficient in 12 of 15 (80 percent) facilities visited. VHA policy requires facilities to maintain accountability of all schedule II-V controlled substances and to fully comply with all U.S. Drug Enforcement Administration regulations governing prescribing, storing, dispensing, and disposing of controlled substances. The primary control to ensure compliance with VHA policy is unannounced monthly controlled substances inspections.

- Medical Care Cost Fund collections were deficient in 11 of 15 (73 percent) facilities visited. With the continuing goal of generating alternative revenue funding, medical care that has the potential to generate revenue must be reviewed for complete documentation of the care provided.

- Agent cashier controls were deficient in 10 of 15 (67 percent) facilities visited. Unannounced audits of the agent cashier should be conducted by at least two employees skilled in fiscal or auditing techniques, and audits should be randomly scheduled at least every 90 days. The level of an agent's cash advance should be based on actual average monthly demand.

- Timekeeping procedures for part-time physicians were deficient in 9 of 15 (60 percent) facilities visited. Controls have been established to ensure that part-time physicians are on duty as required and that absences were properly charged to these employees.

- Purchase card controls were deficient in 9 of 15 (60 percent) facilities visited. The General Services Administration instituted a decentralized purchasing program for direct purchases under $2,500 using Government purchase cards. To reduce the opportunity for fraud and abuse, policy and procedures have been established governing the use of purchase cards, setting purchasing limits, and accounting for purchases. Internal controls over purchase card program activities help to provide management with reasonable assurance that the program will operate efficiently and effectively.

- Medical supply, processing, and distribution were deficient in 9 of 15 (60 percent) facilities visited. Inventory levels should not exceed current requirements so funds are not tied up in excess inventories.

- Service contract controls or contract file documentation were deficient in 9 of 15 (60 percent) facilities visited. VHA facilities use clinical services contracts with affiliated medical schools, community hospitals, and physician practice groups to support patient care. VHA facilities should establish adequate controls to meet two important goals. First, the contract negotiation process should ensure that VA's costs are appropriate and reasonable for the services provided. Second, contract administration procedures should ensure that VA receives all contracted services and pays only for services provided in accordance with contract terms.

- Inventory (non-medical) management was deficient in 6 of 15 (40 percent) facilities visited. The OIG has identified inventory management as one of VHA's most serious management challenges. Inventory levels should not exceed current requirements so funds are not tied up in excess inventories.

- Medical coding was deficient in 5 of 15 (33 percent) facilities visited. It is essential that VHA assure that appropriate and accurate claims are filed and that all claims are supported by medical record documentation.

- Pharmacy security was deficient in 5 of 15 (33 percent) facilities visited. Each facility must install electronic systems in pharmacies to monitor access to controlled substances.

- Rates and inspections at community nursing homes were deficient in 4 of 15 (27 percent) facilities visited. VHA requires an annual certification that community nursing home contracts conform to VHA's rate policy. VHA also requires an annual multidisciplinary team to conduct on-site evaluation of community nursing homes.

- Means test documentation was deficient in 4 of 15 (27 percent) facilities visited. VHA requires certain patients to report income information so VHA staff can determine entitlement to free medical care. In 1997 and again in 1999, we reported that VHA was computer matching veterans' income information that was not supported by signed means test forms. Because these findings showed continued violations of the terms of the matching agreement, the Internal Revenue Service (IRS) terminated the agreement in July 1999. The purpose of the CAP review was to determine whether medical centers made progress complying with IRS requirements for income verification matches.

- Undelivered orders or unobligated balances controls were deficient in 4 of 15 (27 percent) facilities visited. VA requires monthly reviews of accrued services payable and undelivered orders that appear to have been outstanding for unreasonable lengths of time, including undelivered orders that have been inactive for 90 days or more.

- Accounts receivable (other than Medical Care Cost Fund) was deficient in 3 of 15 (20 percent) facilities visited. VA policy requires facility personnel to follow up aggressively on accounts receivable.

- Equipment accountability was deficient in 3 of 15 (20 percent) facilities visited. VHA policy requires that nonexpendable equipment be inventoried at least every 2 years.

Health Care Management

- Pain management was deficient in 5 of 15 (33 percent) facilities visited. VHA was progressing well in implementing its pain management initiatives. We made suggestions for improvement to implement policy consistently, document the extent patients and their families are educated about managing pain, and monitor and evaluate the processes to better treat patients pain.

- Prescribing controlled substances to mental health patients was deficient in 6 of 15 (40 percent) facilities visited. Prescriptions of narcotics for long-term maintenance use such as chronic pain control needed to be more consistently justified in medical records. Clinicians inconsistently considered or documented referrals to alternative treatment modalities such as pain clinics. Additionally, clinical reasons for prescribing narcotics and treatment contracts with patients were not always documented in the records we reviewed. Prescribing drugs to patients for long periods increases the risk of abuse and undesirable side effects.

- Quality management program was deficient in 6 of 15 (40 percent) facilities visited. Quality management staff collected meaningful data, but did not always communicate the results of their analyses and findings to clinical and line managers. Therefore, management may have missed opportunities to identify, evaluate, and correct actual or potentially harmful circumstances that may adversely affect patient safety and treatment.

- Sanitation and cleanliness was deficient in 6 of 15 (40 percent) facilities visited. We found instances of peeling paint, stained or missing ceiling tiles, cut or torn window screens, broken tiles in restrooms, poor signage, improperly stored cleaning supplies, and other sanitation and cleanliness issues.

- Visits to community nursing homes were deficient in 5 of 15 (33 percent) facilities. VA patients that were hospitalized in community nursing homes were not always visited by a VA employee at intervals required by VA policy. Also suggested improvements were made to ensure adequate care and safety.

Survey Results

Employee Surveys

Employee feedback was obtained by mailing questionnaires to clinical employees of 11 VA facilities between May and September 2001. Completion of the questionnaires was optional, and employees' responses were anonymous. During this period, we mailed 3,722 surveys and received 1,766 anonymous responses. This represents a 47 percent response rate. Since we began performing CAP reviews, we have asked for employees' perceptions on a wide range of issues. We believe the resulting data can provide an independent, objective indicator of employee satisfaction for facility management to use in decision-making.

Employees generally felt supported in their efforts to provide quality patient care; however, they perceived that additional emphasis is needed to ensure positive employee morale. Eighty-three percent of the respondents believed the quality of care at their respective facilities was either good, very good, or excellent. Seventy-three percent indicated they would recommend treatment to family members or friends. Fifty-two percent indicated staffing was not sufficient to provide adequate care to all patients. Feedback included concerns for the safety of patients and staff, as well as the assertion that it was not possible to deliver comprehensive care without sufficient nursing and specialty resources. Although 87 percent of employees reported they were generally comfortable in self-reporting errors that involved patient care, only 72 percent indicated they were comfortable reporting errors that involved colleagues. Furthermore, only 56 percent believed that constructive actions were taken when errors were reported. The results of the surveys received after each CAP were shared with managers at that facility.

Physical Plant Environment Surveys

We inspected clinical care areas at 10 facilities, conducting 106 individual area inspections. We performed the largest numbers of inspections in outpatient clinic areas, followed by inpatient wards. Other areas inspected included domiciliaries, emergency rooms, nursing home care units, and operating rooms. In summary, facility managers needed to improve ongoing processes to secure medications, provide unobstructed hallways, ensure privacy, and maintain cleanliness. In addition, facility managers should post the patient representative name, location, and phone number in case patients or family members wish to voice a complaint or concern.

Inpatient Surveys

We interviewed 144 inpatients in 10 VAMCs, including inpatients in mental health, medical,

surgical, long-term care, and intensive care units. Unless inpatients expressed concerns that were consistent with other sources (i.e. outpatients, employees, etc.), inspectors did not validate the inpatients' perceptions, but we discussed issues with local management officials. Inpatients expressed general satisfaction with the quality of care and services they received in VHA facilities.

Outpatient Surveys

We surveyed 270 outpatients at 10 different health care facilities to ascertain patient satisfaction with ambulatory care and related services in VHA facilities. The 10 facilities included 8 VAMCs and/or health care systems, and 2 outpatient clinics. Inspectors interviewed outpatients in various clinics and treatment locations, including primary care, mental health, and specialty care clinics. We also surveyed outpatients in waiting areas of various support services such as pharmacy, radiology, and laboratory.

Ninety-three percent of the outpatients rated the quality of their care and services as good, very good, or excellent, and 90 percent said they would recommend VA medical care to an eligible family member or friend. Ninety percent of the outpatients told us they felt involved in decisions about their care. Eighty-five percent stated they received counseling by a pharmacist when they received a new prescription.

Many of the outpatients we interviewed expressed concerns about access to care and timeliness of services. For example, only 70 percent of the outpatients we interviewed told us they were generally able to schedule an appointment with their primary care provider within 7 days of their request. Pharmacy timeliness also remains a concern. Only 50 percent of the outpatients told us they received their prescriptions within 30 minutes.

Combined Assessment Program Overview - Benefits

In FY 2001, we expanded our CAP program services to include coverage of VBA programs. These reviews focus on the delivery of monetary benefits to veterans and their dependents.

In VBA CAP reviews, auditors assess whether management controls are in place and working effectively. Healthcare inspectors and investigators assess key areas of concern derived from a concentrated and continuing analysis of VBA, VA regional office (VARO), and management information. Also, investigators conduct fraud and integrity awareness briefings.

During this period, we issued two CAP reports on the delivery of benefits, one of which was a VA medical and regional office center. During these visits, the Office of Investigations conducted 18 fraud and integrity briefings for approximately 1,100 employees.

CAP Review, VA Regional Office Phoenix, AZ

We concluded that the VARO's financial and administrative activities were generally operating effectively. We found no significant deficiencies in several of the activities reviewed, including accounts reconciliation, fiscal one-time/advance payments, unassociated accounts, the decision review officer program, large one-time benefit payments, and loan production and property management sections. While the VARO's balanced scorecard indicated that timeliness of claims processing generally improved over the period November 1999 to November 2000, additional improvement is needed. The facility increased its balanced scorecard ratings for 6 of 10 speed measures (timeliness) in compensation and pension, loan guaranty, and vocational rehabilitation and employment (VRE). However, timeliness was below national averages for rating

VA Regional Office
Phoenix, AZ

related actions, appeals resolution, and fiduciary activities in the Veterans Service Center; and days to notification and days to employment in VRE. We made recommendations to improve: (i) timeliness of Veterans Service Center and VRE claims processing, (ii) benefit debt prevention procedures, (iii) coordination of health care services with Arizona VA medical centers for VRE participants and visits to incompetent veterans, (iv) documentation of fiduciary field examination reports and VRE veteran folders, and (v) security of automated information systems and the benefits delivery network. We also identified other areas that warranted management attention. The Regional Office Director concurred with the findings and recommendations and provided acceptable implementation plans.

CAP Review, Royal C. Johnson Memorial VA Medical and Regional Office Center, Sioux Falls, SD

VAMC recommendations were covered previously in the medical overview. For regional office operations, we made recommendations and suggestions in the following areas: security of claim folders, physical security for information technology, information technology access, and internal controls over returned mail. The Medical and Regional Office Center Director concurred with all recommendations and suggestions and reported acceptable implementation actions.

"I would like to take this opportunity … to state that the CAP OIG survey was a value-added survey. In addition, as the newly appointed Director/Chief Operating Officer, I along with leadership viewed this external assessment as a valuable tool to identify areas of concern we needed to address in order to provide the best patient care services and benefits. …The new CAP survey process was beneficial to leadership in validating needs for patient focused process improvements. As a result timely action plans were made and completed."

Director
Sioux Falls Medical and
Regional Office Center

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.

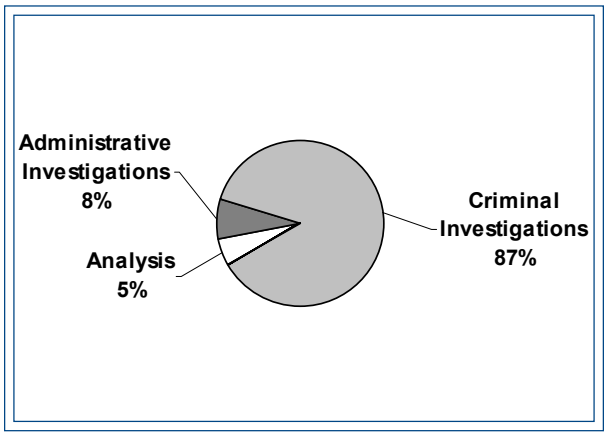
I. Criminal Investigations Division - The Division is primarily responsible for conducting investigations into allegations of criminal activities related to the programs and operations of VA. Criminal violations are referred to the Department of Justice for prosecution. The Division is also responsible 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 108 FTE allocated to the following areas.



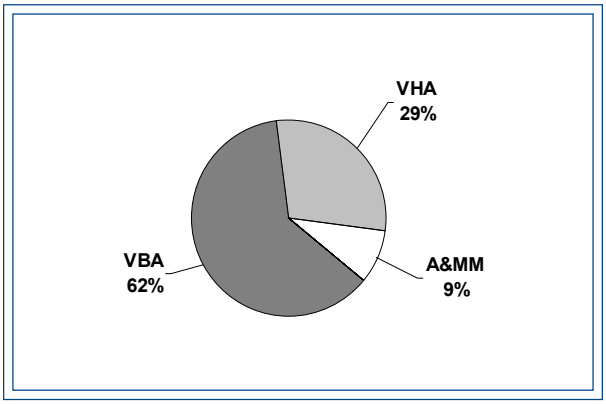
I. CRIMINAL INVESTIGATIONS DIVISION

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 90 FTE for its headquarters and 20 field locations. These individuals are deployed in the following program areas:



Overall Performance

Output

- 329 investigations were concluded during the reporting period.

Outcome

- Arrests - 186
- Indictments - 175
- Convictions - 165
- Monetary benefits - $26.1 million ($17.4 million - fines, penalties, restitutions, and civil judgements; $6.2 million - efficiencies/funds put to better use; and $2.5 million - recoveries)
- Administrative sanctions - 208

Significant Investigative Activities

In the wake of the September 11, 2001, terrorist attacks on the United States, the Office of Investigations committed significant resources to assist in the investigation. Special agents from VA OIG's New York City and Newark, New Jersey offices have worked on a rotating basis alongside other Federal and local law enforcement teams that descended on the downed buildings. Located at the Staten Island World Trade Center debris recovery site, agents searched for victim remains, and collected and cataloged evidence, personal effects, and other items from the disaster such as cell phones, identification cards, drivers' licenses, and business records.

VA Investigators work with FBI and others searching the World Trade Center wreckage following the September 11, 2001, terrorist attack

Agents were required to wear protective clothing as they searched through World Trade Center debris that had been shipped to the Staten Island site.

VHA VISN 3 assisted in the recovery efforts by making a vehicle available to the OIG personnel working at the Staten Island site and by providing a mobile treatment unit for use in treating workers who were injured on the job. Injuries, ranging from cuts and abrasions to respiratory and other more serious problems, are occurring at the rate of about 15 a day.

VA medical van joins FBI medical complex at Staten Island debris recovery site

VA OIG agents have been detailed to the FBI for an undetermined length of time to assist in investigative activities. We are also coordinating the temporary detail of members of investigative staff to the U.S. Air Marshall Program. Although these activities differ from the VA OIG's traditional law enforcement mission, the office stands prepared to assist in any capacity to support other law enforcement organizations in the investigative efforts relating to the terrorist acts perpetrated against our nation.

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.

Suspicious Patient Deaths/Murder

A U.S. District Court sanctioned a former VAMC registered nurse with criminal monetary penalties consisting of a $1.5 million fine and $29,933 in restitution. The individual was previously sentenced to four consecutive life term imprisonments for murdering patients at the VAMC.

Employee Integrity

Theft/Diversion of Pharmaceuticals

- A nursing home care unit nurse entered a plea of guilty to possession of Oxycodone. The nurse was diverting 5 mg Oxycodone with Acetaminophen, a schedule II drug, from patients on his ward. He also admitted removing Percocet tablets from the nursing home. He recorded the Percocet tablets that he took as being administered to patients who had an "as needed" prescription for the Oxycodone. The patients had not requested the medications.

- A former VAMC pharmacy technician was indicted for eight counts of possession of a controlled substance and eight counts of causing misbranding of a drug. Investigation disclosed that while he packaged OxyContin and Percocet for delivery to patients via U.S. Mail, he stole some of the drugs for his own use. This joint investigation was conducted by the VA OIG and VA police.

- Three former VAMC employees pleaded guilty to various charges in connection with the sale of illegal drugs to patients at a VAMC. One subject was sentenced to 33 months' incarceration and 3 years' probation. A second subject received a sentence of 5 months' incarceration, 5 months' home confinement, and 3 years' supervised release. The third subject was sentenced to 180 days' home confinement and 3 years' probation. Following their arrests, the trio resigned their VA positions. This was a joint investigation with the state drug enforcement agency group.

- A former VAMC certified registered nurse anesthetist was charged in a five count indictment for tampering with consumer products, theft of Government property, unlawful possession of a controlled substance by fraud, and other related

charges. The investigation disclosed the individual illegally diverted the controlled substance Fentanyl while acting in his official capacity. In some instances, he substituted Esmolol, a beta-blocker, for the pain reliever Fentanyl, to conceal his illegal acts. The VA OIG, VA police, local police, and U.S. Food and Drug Administration (FDA) jointly conducted this investigation.

- A VAMC pharmacist was arrested for theft of VAMC non-controlled drugs. A joint investigation with VA police revealed the pharmacist was stealing a large volume of drugs from the VAMC pharmacy. He then sold the drugs through his own pharmacy, or to a co-conspirator who owned a pharmaceutical distributorship. Prior to the arrest, the VAMC pharmacy was placed under video surveillance and all high dollar drugs were marked with invisible ultraviolet ink. The video surveillance revealed the pharmacist stole VAMC drugs every day that he worked. The search warrant served on the pharmacist's store as well as a consent search of the distributorship resulted in the recovery of a large volume of marked drugs valued at approximately $11,000. The monetary loss to VA is expected to exceed $350,000.

- A former VAMC pharmacist pled guilty to two counts of theft and was sentenced to 2 years' probation, ordered to avoid contact with the VAMC pharmacy, and to continue in a drug treatment program. A joint investigation with VA police revealed that over a 6-month period the pharmacist, who suffered from pain and depression, would search packages to be shipped to patients. When he located packages containing Vicodin, Percocet, or Ritalin, he would remove some or all of the drugs for personal use.

- A former VAMC pharmacy employee was arrested on charges that he aided in an armed robbery of a VAMC pharmacy. The former employee, a co-op student, was charged in a two-count criminal complaint with aiding and abetting a robbery in which controlled substances were taken, and with aiding and abetting the possession of a firearm in connection with the robbery. The former employee provided information and assistance to the individuals who carried out the crime. The robbery resulted in the theft of 3,000 tablets of OxyContin, as well as varying amounts of other narcotic drugs. Street value of the stolen drugs was estimated at over $250,000. This case was investigated jointly with the FBI and VA police.

- A former VAMC maintenance supervisor, pleaded guilty to two counts of rape. The individual had been previously charged and arrested for participating in the rapes of individuals he rendered unconscious with drugs stolen from VA. A joint investigation by the VA OIG, FBI, and VA police revealed the individual drugged the victims and videotaped the offenses. This arrest follows his previous convictions on two counts of manufacturing child pornography and one count of theft of Government property.

- A former VAMC nurse was ordered to pay a fine of $1,000 after pleading guilty to one count of information charging him with possession of a controlled substance. A joint investigation by the VA OIG, VA police, and U.S. Drug Enforcement Administration determined that between 1997 and 1999 the nurse had diverted controlled substances from the VAMC intensive care unit by means of theft and falsifying documents. He then used the drugs for his personal use. Investigation disclosed that during his last year of employment, he was able to divert 6,600 milligrams of morphine, 15,000 milligrams of Demerol, 95 Percocet tablets, and 100 milligrams of Ativan.

- A former VAMC nurse pleaded guilty to a four count criminal information charging her with stealing various narcotics, including OxyContin and morphine, and converting them to her own use. This joint investigation by the VA OIG, FDA, and VA police determined the nurse stole liquid morphine from syringes and replaced the drug with saline solution. In addition, on at least 21 occasions she falsified medical records by stating she had

administered various controlled substances to patients when in fact she had never administered the drugs and diverted them for her own use. As part of a plea agreement, she agreed to relinquish her nursing license and serve 6 months' incarceration.

Theft and Embezzlement

- A VAMC registered nurse working on an intermediate intensive care unit was arrested after being charged with 36 counts of forgery and one count of grand theft. A joint investigation by the VA OIG and VA police was initiated when the nurse came under suspicion for falsifying her timesheets to show overtime hours she never worked. The investigation disclosed 36 instances during a 3-year period in which the employee altered timesheets for personal gain. The loss to VA is $11,000. Termination of the employee is pending.

- A former VAMC prosthetics service chief was sentenced to 12 months in a halfway house and 5 years' supervised release. The individual was previously indicted for ordering computers, computer related goods, and software using the VAMC's procurement system. The items were purchased for his own personal use. Loss to VA is $37,966.

- A former VAMC mailroom employee and domiciliary resident pleaded guilty to charges of filing false statements to the Government. The individual, a veteran, received his job through a compensated work therapy program. During the time of his employment, it was discovered that he had been receiving mail in two names. When confronted about the two names, the individual admitted to having an alias. Subsequent investigation disclosed he had received Social Security account numbers in both names and had applied for supplemental security income benefits in both names.

Theft of Government Property

- A former VAMC canteen service operations clerk was arrested on a warrant after previously being indicted on five counts of theft of Government funds. A canteen service audit determined large cash discrepancies in bank deposits. A joint investigation conducted by the VA OIG and VA police determined the clerk falsified bank deposit slips for accounting purposes and never actually deposited funds into the canteen service bank account between November 2000 and March 2001. As a result of her scheme, $8,169 was stolen from the canteen service for her personal use.

- A VAMC police officer was arrested and charged in a criminal complaint with theft. A joint investigation by the VA OIG, VA police, and a local police department revealed that a laptop computer valued at $2,473 was reported stolen from the VAMC. A computer manufacturer later notified VA that the stolen computer had been located at a repair shop. Information obtained from the repair shop established the identity of the individual that brought the computer in for repair as a VAMC police officer. The individual admitted to possessing the computer, but claimed to have bought it through a street vendor. Pending the outcome of the investigation, the individual forfeited his police credentials.

Credit Card Fraud

A former VA employee pleaded guilty to a 62-count information for illegally accessing a VA computer. The charges are the result of an investigation that established the employee accessed the VAMC computer system to steal patient information and used that information to obtain credit cards that he used to purchase merchandise. The former employee was sentenced to 3 years' probation and ordered to pay $9,095 in restitution.

False Statements

A VA employee was sentenced following a guilty plea to five counts of false claims against the Government. The individual was sentenced to 4 months' incarceration, 36 months' supervised release, and ordered to make restitution of $7,134 to VA. During the course of a VA OIG investigation into alleged time and attendance fraud, the individual admitted in a sworn statement that he falsely claimed and was paid for 353 hours of overtime that he did not work.

Other Employee Misconduct

- An individual pleaded guilty to a misdemeanor charge of making threatening telephone calls. The individual was previously arrested as a result of a VA OIG investigation that disclosed he called a VA mental health clinic and made threats on the voice mail of a VA physician relative to infecting patients with Hepatitis C. The individual, who is a veteran and had been a former employee at the VA clinic, identified himself during the telephone call using his name and last four digits of his Social Security number. During a second phone call on the voice mail of the same physician, the individual said he would share his Hepatitis C with everyone through the patients he sees.

- A former VAMC nurse pleaded guilty to drug related charges and was sentenced to 10 years' probation, and ordered to pay a fine of $2,500 and court cost of $1,560. As a condition of probation, the nurse was also ordered to submit to a drug evaluation and to follow the recommended treatment. The nurse had been arrested and indicted for drug related violations resulting from a joint investigation with the VA OIG, VA police, FDA, and a county sheriff's office task force. Prior to the VA investigation, a state investigated the nurse on similar charges. As a result of the state's investigation, the individual had been sentenced to 5 years' probation and ordered to surrender her nursing license and not seek reinstatement. Per the final disposition order from the joint investigation with the VA OIG, the 5 years' probation was to be served concurrent with the 10 years' probation.

Abuse of Veterans by Caregivers

A grand jury indicted a VA psychiatrist for sexual assault. The indictment resulted from a joint investigation conducted by the VA OIG, VA police, and a local police department sex crimes division. The VA psychiatrist is accused of sexually assaulting a patient under his care at a VA outpatient clinic. Pending the outcome of the investigation and prosecution, the psychiatrist was removed from patient care.

Theft/Diversion of Pharmaceuticals

- Two brothers were indicted in sealed indictments for their role in obtaining health care services and pharmaceuticals by providing false and fictitious information to approximately 16 VA hospitals and over 170 private hospitals throughout 16 states in their efforts to obtain controlled substances. The brothers provided fake insurance cards, false addresses, false employment data, and fictitious medical information to the facilities. The loss to the medical facilities exceeds $101,000. The VA OIG and local police are conducting this investigation.

- A veteran, who previously pleaded guilty to fraudulently obtaining Oxycodone, a controlled substance, was sentenced to 9 months' incarceration and 1 year probation. The veteran received Oxycodone from a VA outpatient clinic while on a VA pain management contract. In violation of his agreement with the VA and federal law, the individual obtained an additional 720 unit doses of Oxycodone, the narcotic for pain, from four different outside physicians during the same period. This investigation was conducted by the VA OIG, VA police, and U.S. Drug Enforcement Administration.

Possession of Illegal Drugs

A former compensated work therapy program participant pleaded guilty to distribution of crack cocaine. The indictment resulted from a joint investigation by VA OIG and VA police involving two separate controlled purchases of crack cocaine from the individual. Evidence relative to an additional transaction showed the individual purchased 400 Tylenol (labeled as Oxycodone) tablets from an informant the day prior to his guilty plea. This resulted in revocation of his bond and immediate incarceration pending sentencing. Further investigation has resulted in the indictment of a veteran who previously sold 200 VA issued Percocet tablets to this individual.

Theft of Government Property

- A former VAMC supply technician pleaded guilty to one count of theft of Government property and was sentenced to 1-year probation. An undercover operation disclosed the individual stole Government property on several occasions. The individual, a former VA employee, admitted to stealing VA owned computers and computer-related equipment.

- A husband and wife were sentenced to 3 years' supervised release and 6 months' home confinement, and ordered to pay $20,256 in restitution. The husband, a veteran rated with a 100 percent service connected disability, and his wife previously pleaded guilty to one count of theft of Government funds. A VA OIG investigation disclosed the veteran's daughter was injured in an automobile accident and had her medical bills paid by the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The daughter was also covered by a private insurance carrier who was ultimately responsible for the medical bills. The veteran's wife disputed who should receive the reimbursement payment from the private insurance company, so the company issued a $21,792 check payable to the veteran's wife and CHAMPVA and sent the check to the veteran's wife. The veteran and his wife then procured a "CHAMPVA" rubber stamp, falsely endorsed the check, and deposited the funds into their personal bank account. They subsequently withdrew the money for personal use.

Theft of Other Property

Five individuals were indicted on charges of wire fraud and false use of Social Security numbers. The charges were filed after a joint VA OIG and U.S. Postal Inspection Service investigation determined the individuals used the identifying data, including names, dates of birth, and Social Security numbers of VAMC patients to obtain cellular phone service and credit cards, transmitting the information by wire.

Misappropriation of Union Funds

A former VAMC technician and former President of a Local American Federation of Government Employees union was sentenced to 5 years' probation and ordered to pay $192,000 restitution. The individual was also ordered to attend a substance abuse and mental health clinic at his own expense. The individual had previously pleaded guilty to a seven-count indictment for embezzling and misappropriating union funds, participating in a conspiracy to commit mail fraud, and making false statements to conceal the embezzlement. The joint investigation by the VA OIG, IRS, and U.S. Department of Labor determined that approximately $190,000 of union funds had been misappropriated by this individual and a former treasurer for the union. Also, at the VAMC a third individual had prepared 31 false tax returns for refunds. These returns were prepared in offices located at the VAMC morgue, hence the case is referred to as "Operation Death and Taxes" by the U.S. Attorneys' office. The two additional individuals have also been sentenced separately for violating a variety of charges to include conspiracy

to bribe public officials, mail fraud, embezzlement, preparing and submitting false tax returns, and possessing a weapon on a Federal installation.

Procurement Fraud

- A four-count felony complaint was filed against an individual charging him with two counts of perjury and two counts of burglary. These charges resulted from a VA OIG investigation into Government purchase card fraud alleged to have been undertaken by the individual and a former VAMC employee. The investigation determined the individual had obtained multiple drivers' licenses using false information, including Social Security numbers. A joint investigation into false identity assumption was initiated with the Social Security Administration (SSA) OIG and a state department of motor vehicles. In the original fraud scheme, the VAMC employee placed orders for goods through three "shell" businesses established by the individual and then acknowledged receipt for the items, when, in fact, none of the goods was received.

- The owner of a heart monitor equipment company and heart monitor laboratory was charged in a criminal information. The individual knowingly introduced into interstate commerce transtelephonic cardiac event loop monitors that contained false information with intent to defraud and mislead consumers. A joint investigation by the VA OIG, FDA, IRS, and U.S. Department of Health and Human Services disclosed the individual had marketed the monitors with labeling that contained false information regarding the manufacturer of the devices and serial numbers, and failed to list other required information. The devices were distributed to Medicare recipients and VA beneficiaries. The investigation also disclosed the individual attempted to evade a large part of the income tax due to the IRS by concealing the nature and extent of his assets and the location thereof.

Contract Fraud

- A corporation and three individuals agreed to pay the Government $275,000 in resolution of a pending false claims matter. The civil agreement further provides for permanent debarment from Government contracts for the corporation and one individual, and a 3-year debarment period for the remaining two subjects. The four subjects had previously pleaded guilty to various criminal charges arising from a product substitution scheme involving the sale of surgical instruments to Government agencies including VA.

- A former manager of a moving and storage company pleaded guilty to mail fraud. The company became the subject of a VA investigation after irregularities were discovered in several Government moves including that of a VAMC director. The investigation revealed that from 1995 to 1998, the company pioneered the use of phony weight certificates for their moves. Motivated by greed, they generated the false weight certificates for the sole purpose of defrauding Government and non-Government customers. Total loss to VA resulting from this scheme was $70,000. The VA OIG, FBI, and National Labor Relations Board investigated this case jointly.

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

An ongoing proactive project is being conducted by the Office of Investigations in coordination with the VA OIG Information Technology and Data Analysis Division. A match is being conducted to identify individuals who may be defrauding VA by receiving VA benefits intended for veterans who have passed away. When indicators of fraud are discovered, the matching results are transmitted to VA OIG investigative field offices for appropriate action. To date, the match has identified in excess of 5,500 possible cases. Over 418 investigative cases have been opened. Investigations have resulted in the actual recovery of $3.1 million, with an additional $8 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $12.7 million. To date, there have been 20 arrests on these cases with several additional cases awaiting judicial actions.

Employee Misconduct

Theft and Embezzlement

A former VA employee was sentenced to 3 years' probation and ordered to pay $2,417 restitution. This sentence resulted from a guilty plea to one-count of theft of Government funds. The former employee, while employed by VA, used her assigned Government credit card to purchase electronic items, furniture, concert tickets, dental services, and a vacation package to France.

Other Employee Misconduct

Five VARO employees signed last chance agreements. By signing the agreements, the employees have agreed to waive any and all civil or administrative appeal rights and have agreed to a probationary period of 1 year. Four of the employees received 30-day suspensions, and one employee, a supervisor, received a 40-day suspension and a demotion from a GS-12 to a GS-11. The five employees have also agreed to pay restitution for their total unaccounted time. The total restitution received was $3,357. The administrative actions were the result of a VA OIG investigation relating to the abuse of administrative leave to donate blood to the American Red Cross. The investigation revealed the VARO employees had taken 4 hours administrative leave for blood donations on several occasions in the past 5 years. However, the American Red Cross had no record of their donations. All the employees stated they had donated blood when they were questioned regarding their donations. The conditions of the agreement of pretrial diversion include 12 months of supervision, pay restitution for time missed, and submission to fingerprinting by the VA OIG.

Loan Guaranty Program Fraud

Loan Origination Fraud

- A homebuilder pleaded guilty to one count of making false statements to the Government. The individual was involved in a scheme to submit false documents in association with home loans that were insured by the Government. In numerous instances, fake gift letters were submitted to conceal the fact that the individual was loaning the homebuyer money in order to qualify them for the mortgage.

- A veteran was sentenced to 8 months' imprisonment, 3 years' supervised probation, and ordered to pay $36,300 restitution. The veteran previously pleaded guilty to one count of making

false statements on a VA home loan application. A joint VA OIG and SSA OIG investigation revealed the veteran inflated his wages from employment in order to qualify for a VA guaranteed home loan. He also withheld information concerning 13 aliases.

- Two individuals were sentenced for their part in an equity-skimming scheme. One defendant was sentenced to 30 months' imprisonment and 36 months' probation upon his release. Restitution for this defendant was set at $38,426. The second individual, a real estate agent, was sentenced to 10 months' imprisonment and 36 months' probation upon her release, and was ordered to pay $10,070 in restitution. A joint investigation by the VA OIG and FBI disclosed the defendants promised homeowners facing foreclosures that they could stop the foreclosures and salvage their credit ratings by transferring their homes to trusts controlled by the defendants. The defendants rented the properties back to the homeowners or other people without paying the outstanding mortgages. The defendants used the rent money they collected for personal expenses. Five of the homeowners had loans guaranteed by VA. Losses to VA in the foreclosures of these properties were approximately $150,000.

Other Loan Guaranty Fraud

An individual pleaded guilty to one count of bankruptcy fraud and one count of issuing a false statement. The individual was sentenced to 24 months' incarceration, 3 years' supervised release, and 300 hours' community service, and ordered to pay restitution of $28,713. This investigation was initiated based on information received from the U.S. Coast Guard that the individual and an associate were involved in a real estate scheme to purchase numerous VA properties. The joint investigation revealed the individual used various Social Security numbers to purchase properties; when the properties went into foreclosure status, he would file bankruptcy to impede the process.

Beneficiary Fraud

Accounting for over 60 percent of the VA OIG investigative case inventory, fraud associated with the VA's benefits payments programs leads to numerous arrests and judicial actions. The following are some of the more significant cases conducting during this semiannual period.

Dependency and Indemnity Compensation Benefits Fraud

- An individual, who was the friend of a widow receiving VA Dependency and Indemnity Compensation (DIC) benefits, was indicted on charges of theft of Government property. Investigation disclosed that following the DIC recipient's death the individual did not report the death to VA. The individual improperly received and used $39,459 in DIC benefits.

- The son of a widow receiving DIC benefits was indicted on charges of theft of Government property and aiding and abetting. Investigation disclosed that following his mother's death the son did not report the death to VA, but rather improperly received and used $54,547 in DIC benefits.

- The daughter of a deceased veteran was sentenced to 3 years' probation, and ordered to pay $40,016 restitution and participate in mental health treatment. The individual previously pleaded guilty to theft of Government funds. For 4 years, the individual failed to report to VA the death of her mother who was receiving widow's benefits under the DIC program. After the mother died, VA continued to directly deposit monies into a joint bank account she held with her daughter. Each month the daughter would withdraw the funds deposited by VA. By this scheme, she wrongfully converted $40,016 to her own use.

- An individual was charged with 44 counts of theft of Government funds related to the fraudulent

receipt of DIC benefits for approximately 20 years. Investigation revealed that from January 1980 through December 1999, the individual failed to notify VA of her remarriage and continued to receive DIC benefits to which she was not entitled. During the same time period, she made false claims for payment to the Government by negotiating U.S. Treasury checks that were issued as payment of DIC benefits. Loss to the Government exceeds $163,000.

- A veteran's widow was sentenced to 5 months' incarceration, 5 months' home confinement and 3 years' supervised probation, and ordered to pay $86,264 in restitution. She had previously pleaded guilty to theft of Government funds. The case was initiated when the SSA OIG notified the VA OIG that the individual had applied for SSA benefits using her deceased husband's name and that she was also receiving SSA benefits as the spouse of another individual. At the same time that she applied for SSA benefits, VA received an anonymous letter indicating the woman was also receiving VA benefits to which she was not entitled. Attached to the anonymous letter was a copy of a marriage certificate indicating the woman had remarried in March 1990. A review of VA files determined that she was in receipt of DIC benefits as the surviving spouse of a deceased veteran, but had failed to notify VA of her remarriage. VA regulations provide that DIC payments cease upon a beneficiary's remarriage.

- The daughter of a DIC beneficiary was sentenced to 36 months' probation with up to 90 days in a residential drug treatment facility, and ordered to pay $55,372 restitution to VA. An investigation by VA OIG disclosed the daughter failed to disclose her mother's death to VA, continued to receive and negotiate 53 U.S. Treasury checks issued to the deceased mother, and deposited these funds into a personal bank account for her own use.

- A veteran's widow was charged with the 1983 murder of her husband, and the theft of over $150,000 in VA benefits. A task force of investigators, including special agents from VA OIG, determined the widow hired another individual to kill her husband so that she could collect his VA and other insurance benefits. Other individuals in this conspiracy have already been charged.

Bangor Daily News
Bangor, ME
Thursday, May 10, 2001


Bangor

Our 112th Year • Issue 280

2 more indicted

By Walter Griffin
Of the NEWS Staff

BELFAST — The investigation of a deadly triangle of greed, betrayal and murder was brought to a close Wednesday when the widow of a man shot to death in his front yard and a former boyfriend of their daughter were arrested and charged with the 17-year-old murder.

A third person — the alleged hit man — involved in the Belfast murder-for-hire death of Mervin

Norma Small, 61, of Gas, Kan., was arrested on a murder-for-hire charge Wednesday while driving through Iola, Kan. Small, who had relinquished her married name after her husband's death, relocated to the Midwest from Maine in 1998.

Grotton

A Waldo

charge Tuesday but th
was kept secret until
Also arrested und
indictment was Boyd
Brooks.
Police allege that
as the go-between in
conspiracy by introdu
Joel Fuller, the man
shooting Grotton.
Fuller, 45,
Searsmont, is serving
sentences for two drug
ders that occurred

- A DIC recipient was indicted on one count of making a false statement. A VA OIG investigation revealed the individual signed and submitted a false VA declaration form stating she had not remarried after the death of her veteran husband, when in fact she had remarried. From the time of her remarriage until her divorce, the individual received approximately $67,000 to which she was not entitled.

- The daughter of a widow receiving DIC benefits was sentenced to 6 months' home detention and 60 months' probation, and ordered to pay $86,709 restitution. The daughter had previously pleaded guilty to one count of theft of Government funds. A joint investigation with the FBI disclosed the individual did not report the death of her mother in May 1990, and continued to negotiate the DIC benefits through September 1998.

- The daughter of a DIC benefits recipient pleaded guilty to a criminal information charging her with theft of Government benefits. The DIC benefits recipient died in October 1989. VA was never notified of the beneficiary's death and continued to disburse the DIC benefits until January 2001. In January 1996, the defendant contacted VA by telephone and changed the payment method to direct deposit into her checking account. From November 1989 through January 2001, the defendant illegally received over $105,000 in DIC benefits to which she was not entitled. Sentencing is pending.

- An individual was sentenced after being found guilty to four counts of mail fraud and one count to theft of Government funds. The individual was sentenced to 27 months' incarceration and 3 years' probation, and ordered to pay $47,552 restitution to VA. The sentencing resulted from a VA OIG investigation that revealed the individual devised a scheme to defraud a Brazilian widow and the children of a Vietnam veteran of DIC benefits.

- The son of a deceased veteran was sentenced to serve 2 years' probation with a special condition of 6 months' home detention for theft of Government funds. The court also ordered the individual to pay VA restitution of $102,000 and to undergo mental health counseling. From April 1989 to September 2000, the veterans' son failed to report to VA the death of his mother who was receiving widow's benefits under the DIC program. VA continued to deposit monies into a joint bank account she held with her son and each month the son would withdraw the cash deposited by VA. By means of this scheme, he wrongfully converted $102,000 to his own use.

- Three daughters of a DIC beneficiary were indicted on one count each of conspiracy to defraud the Government and false claims. Following the 1993 death of the DIC beneficiary, one daughter assumed her mother's identity and continued to receive DIC benefits through February 2000, creating an overpayment of $69,736. The remaining two daughters, both adopted by the deceased beneficiary, were receiving VA benefits as helpless children. An investigation determined that the daughters were not helpless, and the VARO terminated the awards.

Albuquerque Journal
Albuquerque, NM
Friday, May 4, 2001

Impersonation of Dead Mom Alleged

Siblings Indicted in Veteran Benefits Fraud Case

"The agents were outside and could see through a window the defendant wheeling a wheelchair back and forth, stopping, talking amongst each other."

- A former DIC recipient pleaded guilty to one count of mail fraud. The individual, a veteran's widow, was previously indicted on 18 counts of mail fraud after failing to notify VA of her remarriage in 1980. Loss to VA is $155,027. Sentencing is pending.

- Special agents from the VA OIG and SSA OIG arrested the sister of a DIC and Social Security beneficiary. The beneficiary died in June 1997 and her sister failed to inform the VA and SSA of her death. Subsequently, the sister endorsed and cashed the monthly benefits checks and converted the funds for her own use. The total loss to the Government was approximately $37,000. The investigation is continuing.

- The daughter of a deceased VA widow beneficiary was arrested on a warrant after being previously charged with 5 counts of theft of Government funds and 33 counts of bank larceny. This case was initiated based upon a death match

referral which indicated the deceased widow, a recipient of DIC benefits, died in December 1999. A joint investigation conducted by the VA OIG and U.S. Secret Service revealed that between December 1999 and September 2000, the daughter withdrew VA funds that she was not entitled to from her deceased mother's bank account. Loss to the VA is $29,342.

- Two daughters of a DIC beneficiary were sentenced for theft of public money. One daughter was sentenced to 21 months' imprisonment and 3 years' supervised release, and ordered to undergo treatment for cocaine addiction and to pay $22,000 restitution to VA. The other daughter was sentenced to 60 months' probation and 4 months' house arrest, and ordered to pay $14,663 restitution. She will also perform community service as determined by the court. A joint investigation by the VA OIG and U.S. Secret Service disclosed the daughters failed to report their mother's death to the VA and continued to receive DIC payments that were electronically deposited into a joint account they shared with their mother. One daughter admitted to unlawfully taking the VA benefits to support her cocaine habit. The other daughter admitted to unlawfully taking the benefits because of her poor financial condition. Loss to VA totaled $37,000.

- An individual was sentenced to 4 months' incarceration, 4 months' home detention, and 5 years' supervised release, and ordered to pay $50,274 to VA. The individual had previously pleaded guilty to one count of bank fraud involving his deceased mother's bank account. A joint investigation by the VA OIG and U.S. Secret Service disclosed that after his mother, a DIC beneficiary died in 1995, he withdrew monies by forging his mother's name to personal checks made payable to himself. He also forged her name on 14 U.S. Treasury checks and on a direct deposit form, which changed the monthly payments to electronic funds transfer. To continue payment by VA, he forged his mother's name on a marital status questionnaire.

- An individual pleaded guilty to a criminal information involving the theft of Government property. The individual used DIC benefits that were sent to his deceased aunt. An investigation disclosed that after the aunt's death in December 1996, the individual, a co-signor on a joint bank account, continued to receive and spend the DIC funds through February 2001. The individual agreed to pay $58,445 in restitution.

Pension Benefits Fraud

- A veteran pleaded guilty to one count of making false statements. The veteran was granted a VA pension, based on his false claims of zero assets and income. An investigation disclosed the veteran earned interest on personal investments of about $200,000. The loss to VA was $34,071. Sentencing is pending.

- An individual previously charged with a six count information for the theft/conversion of U.S. Treasury checks, pleaded guilty and was sentenced to 1 year probation and ordered to pay $5,208 in restitution. A joint investigation by the VA OIG and U.S. Secret Service disclosed the individual failed to report the death of her alleged common law husband and continued to negotiate $13,744 in VA benefit payments.

- VA OIG agents arrested a former VA beneficiary as she arrived in the United States. The investigation determined the individual had been receiving VA widow pension benefits since 1990 as a surviving spouse of a deceased veteran. Investigation disclosed that in applying for the benefits, the individual falsely certified that she had not remarried when in fact she had remarried 1 month after the death of the veteran. Also, the VA OIG forensic laboratory determined the individual had altered the veteran's original death certificate in order to have it falsely state that she was his current wife. As a result, VA overpaid her $56,636. At the time of the indictment, the individual was a fugitive and her whereabouts

were unknown. Subsequently, the individual contacted a VARO and reported that she was living in Canada, and requested that her benefits be reinstated because she had divorced her husband.

- A veteran was sentenced to 12 months' incarceration and 3 years' supervised release, and ordered to pay VA $79,623 restitution. The veteran had previously pleaded guilty to one count of theft of Government money and one count of false statements. The veteran admitted collecting VA pension benefits since 1993 while failing to report his spouse's income during that time. The veteran submitted income verification reports to VA that indicated he was married, but not living with his spouse. The veteran also indicated he did not know where his spouse was living and did not know her Social Security number. The investigation determined the veteran has continuously resided with his wife who earns substantial income. The spouse's income would have disqualified the veteran from the VA pension program.

- A veteran was indicted by a federal grand jury and charged with one count of theft of Government monies and one count of false statements. The indictment resulted from a VA OIG investigation that revealed the veteran, who was in receipt of VA pension benefits, submitted false documents to VA on which he failed to report his earned income. The loss to the Government is approximately $52,000.

- A veteran pleaded guilty to charges of making false statements and was sentenced to 3 years probation and 6 months' home detention, and ordered to pay $51,000 restitution. An investigation revealed the veteran, who was receiving VA pension benefits, was working from his home brokering transportation shipments for trucking firms. The veteran failed to report his income to VA.

- The daughter of a deceased VA death pension beneficiary entered a plea of nolo contendere on a charge of theft by deception. The daughter was sentenced to 2 years' probation, and ordered to pay fines and fees of $1,052 and restitution of $4,256. An investigation by the VA OIG and local police revealed the daughter failed to notify the VA of her mother's death and cashed 32 VA checks issued after her mother died. This investigation was the result of a death match initiated by the VA OIG.

- A veteran was indicted and charged with two counts of theft of Government funds. The indictment resulted from a VA OIG investigation that revealed the veteran, who was in receipt of VA pension benefits, failed to report his earned income to VA. The loss to the Government is approximately $11,708.

- The widow of a veteran was sentenced to 6 months' home confinement and 5 years' supervised release, and ordered to pay $20,506 restitution. From 1993 through 1998, the defendant submitted eligibility questionnaires to VA stating she was not working and was dependent on VA benefits. The defendant repeatedly accused VA of harassing her and threatened to sue VA if her benefits were terminated. The investigation uncovered the defendant was continuously employed during this time and earned substantial income. The defendant's income would have disqualified her from the VA pension program. The total loss to VA was $20,506.

- A veteran who previously pleaded guilty to theft of Government benefits was sentenced to 5 years' probation and 4 months' home detention, and ordered to pay $16,288 restitution. A joint investigation between the SSA OIG and VA OIG revealed the veteran was employed using his nephew's Social Security number while receiving benefits based on his unemployment status.

Education Benefits Fraud

- A former instructor and a former teaching assistant were sentenced as a result of a 4-year investigation regarding an elaborate educational benefits fraud scheme. The scheme involved approximately 450 veterans who received

educational assistance benefits from VA while enrolled in college where the instructor and teaching assistant worked. The scheme allowed these veterans to obtain a VA paid stipend and course credit without attending regular classes. As part of the scheme, the veterans would occasionally attend a meeting. This meeting was very brief and served to "substitute" for the veterans' attendance in class. During some of these meetings, the veterans would provide kickbacks to the participating instructors and group leaders. The instructor originated the program that facilitated the fraudulent scheme. The teaching assistant served as the head "group leader" of the veterans participating in this scheme. They were convicted after a 6-week trial on 18 counts of conspiracy to defraud the Government, mail fraud, and aiding and abetting mail fraud. The instructor was sentenced to 1 year home detention with 6 months' electronic monitoring, 3 years' probation, 250 hours' community service, and a $900 special assessment fee. The teaching assistant was sentenced to 1 year home confinement, 3 years' probation, 150 hours' community service, and a $900 special assessment fee.

Compensation Benefits Fraud

- A veteran's son pleaded guilty to 16 felony counts of forgery. He was sentenced to 4 years' imprisonment and ordered to pay $5,014 restitution to VA. A joint investigation by the VA OIG and local authorities disclosed the son failed to report his father's death to VA and continued to receive VA compensation benefits checks that were being mailed to his deceased father. The individual forged his father's signature on VA benefits checks and then diverted the money for his own personal use.

- The brother of a veteran who received VA compensation benefits pleaded guilty to theft of Government property. The veteran died in May 1997; VA was never notified of the veteran's death and continued to disburse the compensation benefits until January 2001. A joint investigation by the VA OIG and U.S. Postal Inspection Service revealed the brother assumed the veteran's identity and obtained U.S. Treasury checks from postal officials who believed he was the veteran. From June 1997 through January 2001, the defendant illegally received over $93,000 in VA compensation benefits. Sentencing is scheduled.

- A veteran was sentenced to 30 months' imprisonment to run consecutively with a prior 157-month prison sentence. The veteran was also ordered to pay restitution to VA and serve a 3-year term of supervised probation upon his release from prison. Previously, the veteran was ordered to serve 157 months imprisonment for possession of explosive devices and threatening to kill former President Clinton. A joint investigation by the VA OIG and FBI revealed for the past 15 years the veteran defrauded VA and received over $260,000 in compensation benefits. The veteran made false claims about his military service while in Vietnam, including that he was wounded in combat and witnessed numerous traumatic incidents. The investigation proved that the veteran altered his own service medical records to show that he was wounded in combat and lied about all the events he used to obtain a 100 percent disability rating.

- A former U.S. Postal Service employee was indicted on nine counts of fraud for filing false claims and making false statements relating to VA, SSA, and U.S. Department of Labor programs. The joint investigation by the VA OIG, SSA OIG, and U.S. Postal Inspection Service disclosed the former employee filed false claims and made false statements to the aforementioned agencies relating to an alleged on-the-job injury sustained during her employment with the U.S. Postal Service. The individual failed to inform the Government agencies of her ability to work and medical condition. Her actions caused false documents to be filed to initiate new claims and increase benefit payments she was already receiving. In January 1992, she made an application for compensation with VA for a claimed back injury while on active duty and

received a 10 percent compensation award. In 1994, this award was increased to 20 percent based upon her claim that the condition worsened. In 1998, the individual further defrauded the VA by requesting another increase in her benefits based upon false statements regarding her physical condition. Subsequently, she received over $70,000 in compensation benefits to which she was not entitled.

- The brother of a deceased veteran was sentenced to 10 months' incarceration and 36 months' supervised probation, and ordered to pay $93,601 restitution to VA. The brother had pleaded guilty to theft of Government funds. A joint investigation by the VA OIG and U.S. Postal Inspection Service disclosed that for almost 4 years the brother had assumed the deceased veteran's identity to obtain VA disability compensation benefits. The VA OIG, based on surveillance at the post office, identified the subject. On the first of each month, the subject would present himself at the post office and represent to the postal clerks that he was the veteran. The clerks would give him the check and he would immediately cash it at a nearby store using false identification. Loss to VA is $93,601.

- An individual previously charged with a one count indictment for the theft/conversion of VA compensation benefit payments, was arrested by VA OIG and U.S. Marshals Service agents. A VA OIG investigation disclosed the individual failed to report the death of his father and continued to negotiate over $20,000 in VA benefit payments. The payments were intended as service connected disability compensation benefit payments for the individual's father, a veteran.

- A veteran in receipt of individual unemployability benefits was indicted on two counts of theft of public money, two counts of false statements, and one count of failure to disclose information. A joint investigation by the VA OIG and SSA OIG disclosed the veteran devised a scheme whereby, from 1995 through 2001, he circumvented the requirement to report his employment to VA and SSA by conducting business through a company incorporated and owned by his wife. In 1994, VA rated the veteran 80 percent disabled for his service-connected illness and granted him individual unemployability. From 1995 through 2001, the veteran drove a commercial truck on a full time basis while submitting false statements to VA and SSA certifying that his medical condition had not improved. The loss to VA and SSA is $163,663.

Fiduciary Fraud

- An individual was sentenced to 12 months' incarceration and 36 months' supervised release. The individual previously pleaded guilty to one count of submitting false statements, one count of Social Security fraud, and one count of failure to appear for trial. A joint investigation by VA OIG and SSA OIG determined the individual, acting in the capacity of her husband's fiduciary, fraudulently claimed the dependency of two minor children and collected additional VA and SSA benefits. One child was not the husband's dependent and the other child did not exist.

- An individual was indicted and charged with one count of misappropriation of funds by a fiduciary. The indictment was the result of a VA OIG investigation that revealed the individual, while appointed as his veteran brother's guardian, misappropriated $13,974 paid by VA for the care of the incompetent veteran.

- A fiduciary was sentenced to 4 years' probation, 6 months' home detention, and 400 hours' community service, and ordered to pay $12,055 in restitution. The individual had previously pleaded guilty to one count of concealing and failing to disclose with intent to defraud the Government. A joint investigation by the VA OIG and SSA OIG disclosed the fiduciary acted with knowledge when she failed to report the

death of a veteran beneficiary, her grandfather, and continued to use his VA and SSA benefits for her personal expenses. The loss to VA and SSA is approximately $24,314.

- An individual was indicted and charged with one count of misappropriation by a fiduciary. A VA OIG investigation revealed the fiduciary fraudulently received and spent three of her grandson's DIC checks after he was removed from her custody. Loss to VA is approximately $1,119. Additionally, it appears the fiduciary misappropriated $23,290 of the service members' group life insurance proceeds.

- A former attorney was sentenced to serve 12 months' incarceration, 3 years' supervised release, and ordered to pay $38,158 in restitution. The individual previously pleaded guilty to one count of theft of funds after being named in an indictment that charged him with multiple counts of fiduciary fraud. The sentencing is the result of a VA OIG investigation that determined the individual, a court-appointed financial guardian for a disabled veteran, filed a false accounting with a state court and with VA. The individual also diverted in excess of $13,000 of the veteran's VA benefits for his own personal use.

Theft of Benefits

- An individual was sentenced to 18 months' confinement and 5 years' supervised probation, and ordered to pay a special assessment of $2,600. A jury convicted the individual on all 26 counts of an indictment that had charged him with bank and mail fraud, theft of Government property, and forgery. This case was initiated after 13 U.S. Treasury checks were reported missing by VA beneficiaries. A joint investigation with VA OIG and U.S. Secret Service disclosed the stolen checks totaling over $48,000 had been deposited in the individual's bank account. Subsequent handwriting analysis identified the individual as the author of forged signatures and other entries on the checks. Prior to his arrest, the individual contacted the bank and asked that his account be closed and a payoff check be written to him. Bank authorities, suspecting wrongdoing, had been in touch with VA OIG representatives and stopped payment on the payoff check.

- An individual was indicted on charges of theft by unlawful taking. While impersonating a veteran, the individual was able to transfer the veteran's monthly VA benefit payments to his own account. At the time of his arrest, he was in possession of numerous fictitious identification cards. The subject is currently incarcerated for bank robbery. This is a joint investigation with a local police department and prosecutor's office.

- An individual was indicted and charged with two counts of wire fraud. The charges were filed following a joint investigation by the VA OIG and SSA OIG. Investigation determined the individual, son of a deceased widow, knowingly concealed his mother's death and withdrew funds from the widow's bank account for his own personal use. The widow was simultaneously receiving both VA and Social Security benefits. VA and SSA loss exceeds $90,000.

- An individual was sentenced to 12 months' incarceration and 36 months' probation, and ordered to pay $51,865 restitution to VA. The individual had previously pleaded guilty to one count of wire fraud relative to his diversion of VA benefits payable to a deceased veteran whom he claimed was his uncle. The VA benefits were electronically deposited in one state and withdrawn by the individual through automated teller machines in another state.

- A former VA employee was sentenced after pleading guilty to multiple counts of theft, mail and wire fraud, and conspiracy. The individual was sentenced to serve 2 years' incarceration and 3 years' probation, and ordered to pay $229,786 in restitution. The sentencing was the result of a VA OIG investigation that determined the employee, in her capacity as a senior veteran services representative, created a false veteran payee

within VA data systems. This caused VA to issue benefit checks in the name of a fictitious veteran to an address controlled by her associate. It continued for 3 years. The employee then negotiated the checks. Her associate, a co-conspirator, was previously sentenced after pleading guilty to similar charges.

- A grand jury indicted an individual on one count of bank fraud. The indictment resulted from a VA OIG investigation that determined from April 1997 through May 2000, the individual used an automated teller machine card to withdraw his deceased mother's VA benefits. The loss to VA is $33,315.

- An individual was indicted and charged with two counts of forgery of U.S. Treasury checks. The indictment was the result of a VA OIG investigation that revealed the individual was forging and cashing VA benefit checks issued in the name of his former girlfriend without her consent. Total loss to the Government is $10,049.

- A grand jury returned an indictment charging a veteran with false representation of a Social Security account number and fraudulent acceptance of payments. Investigation revealed the veteran presented his son's Social Security number as his own while securing employment. This misrepresentation enabled the veteran to conceal his earnings and thus receive VA and Social Security benefits to which he was not entitled. Loss to VA exceeds $10,700.

- An individual pleaded guilty to submitting a false document to VA. The individual submitted an altered death certificate to VA stating his mother-in-law died in June 2000. The mother-in-law had actually died in November 1991. The individual provided the false death certificate in order to extend his deceased mother-in-law's VA benefits past the required termination date. An investigation disclosed the individual received VA benefits payments totaling $90,503 and used the funds for his own purposes. This inquiry stemmed from a VA OIG and SSA death match of Social Security decedents and VA benefits payees.

- An individual pleaded guilty to one count of false representation with intent to defraud the Government. The individual was previously indicted on one count of false representation with intent to defraud and one count of producing a counterfeit access device affecting interstate commerce. Investigation revealed the individual concealed the death of his grandmother, a VA and SSA beneficiary, and continued to use her benefits for personal expenses. The loss to the Government was $32,014. This is a joint VA OIG and SSA OIG case.

Other Benefits Fraud

- A VA employee and two accomplices were released on $50,000 bond after appearing on charges of theft of Government property and conspiracy. An investigation by the VA OIG, FBI,

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The Atlanta

WEDNESDAY, AUG. 29, 2001

$6 million scam exploited dead vets

By BILL RANKIN
brankin@ajc.com

By fictitiously resurrecting the dead, a claims supervisor and two accomplices defrauded the Department of Veterans Affairs out of almost $6 million, federal prosecutors charged Tuesday.

With the proceeds, the three suspects went on a luxury spending spree, buying homes, a trip to Paris, a small submarine, a hovercraft, cars and a light aircraft, according to court records.

The scheme allegedly was orchestrated by Sarah Prater, a claims examiner and congressional liaison for the VA's regional office in Atlanta.

Prater, 60, of Atlanta used her security clearance to access the computer files of deceased veterans and "resurrect" them, prosecutors said. She would make a full disability claim on behalf of those veterans and with the name of co-defendant Ernest Thornton, prosecutors said.

Payments were sent to post office boxes in the names of Thornton, 42, of Hiram and Kathy Eselhorst, 52, of Lilburn, prosecutors said. Thornton and Eselhorst both formerly worked for the VA.

All three suspects were released on $50,000 bond Tuesday.

From July 1996 until this month, 246 fraudulent disability payments were made, totaling $5.95 million, according to an affidavit by R. Darlene Perkins from the VA's inspector general's office.

Assistant U.S. Attorney Barbara Nelan said authorities have so far identified only what amounts to "chump change" of all that was stolen from the VA.

According to Perkins' affidavit, the three suspects admitted to the fraud scheme during a

and U.S. Postal Inspection Service disclosed that a VA employee and her two accomplices, both former VA employees, defrauded VA out of approximately $11 million between 1993 and August 2001. Further investigation revealed the VA employee accessed and falsified numerous files to generate hundreds of benefit payments to veterans who had died and had no beneficiaries. Subsequently, large retroactive benefits checks were disbursed or electronically deposited into accounts belonging to the accomplices and used for their own personal use. Ten additional co-conspirators, who are not VA employees, have also been charged. The investigation continues.

- A veteran and his son were indicted on one count of making false statements and one count of making false claims. The son was also charged with aiding and abetting his father in these criminal violations. An OIG investigation revealed the veteran provided a false VA medical expense report, claiming $33,659 in medical expenses. Furthermore, the investigation found the veteran provided false receipts of $26,390 to substantiate the medical expenses claimed. The veteran's son admitted to helping his father with the receipts. As a result of their actions, the veteran received a VA pension that he was not entitled, and the VA incurred a loss of $11,289. Further judicial actions are pending.

- Two brothers of a deceased veteran were each sentenced to 37 months' incarceration and 36 months' probation, and each ordered to pay $67,189 in restitution. A joint investigation by the VA OIG, SSA OIG, and Defense Criminal Investigative Service disclosed the veteran's wife, brothers, and mother conspired to fake the veteran's death and then illegally enrich themselves by applying for and receiving VA, SSA, and Servicemen's Group Life Insurance benefits totaling over $300,000. The veteran was an active duty U.S. Marine who faced court martial for child molestation. To avoid those charges, he faked his death by killing another individual and burning the body in a trailer fire. The body was never identified. The veteran was subsequently found living under another identity, and convicted of other molestation charges for which he received a sentence of 45 years' imprisonment. The veteran later hung himself in his jail cell to avoid the state murder and arson charges, Federal fraud charges, and military court martial. In June, the former wife was sentenced to 36 months' probation and ordered to pay $101,874 in restitution. The mother is scheduled for sentencing at a later date.

Las Vegas Review-Journal
Las Vegas, NV
Thursday, April 12, 2001

BENNETT CASE

Relatives convicted of fraud

Three guilty of plotting with Marine

By CARRI GEER THEVENOT
REVIEW-JOURNAL

Marine Staff Sgt. Arthur Bennett killed himself before he could be tried in the case, but three of his relatives were convicted Wednesday of conspiring with him to defraud the federal government.

"If there was a way for us to convict the Marines of being stupid, we should have, but we couldn't do that," juror Dan Zook said.

Bennett, 43, repeatedly shook his head.

"I'm still shocked," he said several hours later.

Scott Bennett's two teen-age daughters fled the courtroom in tears after hearing the jury's decision.

None of the defendants testified during the two-week trial, and David Bennett said he regrets his decision not to address the jury. He vowed to appeal his conviction.

"We're paying for the Marine Corps' guilt, and I totally believe that," he said.

Defense attorneys repeatedly attacked the Marine Corps during the trial.

Karen Connolly, who represents Ellen Bennett, accused military officials of assisting Arthur Bennett with his plot, either inadvertently or intentionally.

- A woman and her three daughters pled guilty to mail fraud and false statement charges. A joint investigation by the VA OIG; SSA OIG; Bureau of Alcohol, Tobacco and Firearms; U.S. Postal Inspection Service; and a state department of insurance fraud division disclosed the women engaged in a scheme to commit fraud, make false claims, and embezzle funds belonging to VA and SSA benefits recipients deemed incompetent. The investigation also disclosed the woman misused the identity of a 100 percent service-connected disabled veteran and purchased luxury vehicles and jewelry and obtained credit accounts in the veteran's name. This veteran's name was also used in connection with fraudulent claims related to bogus automobile accidents. Sentencing is scheduled for October.

- An individual was arrested on state charges for first-degree forgery. The individual forged and cashed VA benefit checks issued to his mother subsequent to her death in December 1994. This case was a joint investigation by the VA OIG, U.S. Secret Service, and a local police department. Total amount of forged checks is $21,060.

- A veteran was arrested based on a complaint charging him with forgery and money laundering. A joint investigation with VA OIG and the U.S. Postal Inspection Service revealed the veteran stole checks totaling $26,943 along with the victims' identification. The veteran then assumed the identity of two different persons, including another veteran, in furtherance of this scheme. One stolen check was deposited into his own account. The second check was used to open an account using the victim's stolen identification.

Credit Card Fraud

A former student trainee pleaded guilty to one count of credit card fraud. The individual had been previously indicted for conspiracy to commit credit card fraud. The indictment followed a joint investigation by the VA OIG and U.S. Postal Inspection Service regarding allegations that the individual was fraudulently obtaining credit cards using the names and personal information of VA employees. He would generally use convenience checks to withdraw funds from these accounts and deposit them into his bank accounts. Approximately $43,000 in fraudulent charges were made on the credit card accounts opened by the individual.

OIG Forensic Document Laboratory

The OIG operates a nationwide forensic document laboratory service for fraud detection that can be used by all elements of 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 34 reports issued during this semiannual period.

Laboratory Cases for the Period

Requester	Cases Completed
OIG Office of Investigations	12
VA Regional Offices	19
Office of Security and Law Enforcement	1
Other	2
TOTAL	**34**

The following are examples of completed laboratory work:

- A joint task force has been formed between the VA OIG and the U.S. Secret Service to conduct a review of potential VA benefits fraud at a VARO. The laboratory provided assistance in

the review of 231 individual claims folders for indications of fraud. The review identified 66 files requiring further investigation.

- A veteran submitted a clinical record and physical examination that would have provided a basis for additional VA benefits. Laboratory examinations determined the medical records were fraudulent and prevented $63,210 in VA benefits losses.

- A veteran's widow provided a medical record containing information that would have been required to obtain additional VA benefits. The laboratory determined the document was fraudulent and prevented a $27,330 loss in VA benefits.

- The VA OIG investigated a VAMC employee who stole checks from a deceased veteran to obtain money. The laboratory determined the employee forged checks on the veteran's bank account.

- The VA OIG investigated an individual who obtained $58,479 in death pension benefits by not reporting her true income. Laboratory examinations identified her as the author of signatures on critical fraudulent documents.

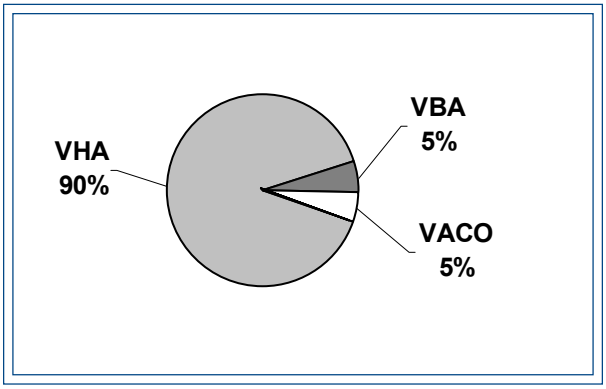
II. ADMINISTRATIVE INVESTIGATIONS DIVISION

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 allocated. The following chart shows the percentage of resources utilized in reviewing allegations by program area.



Overall Performance

During the reporting period, the Division closed 26 cases.

Output

- During the reporting period, nine reports and four advisory memoranda were issued, including one case with both a report and an advisory memorandum issued. Fourteen cases resulted in administrative closures.

Outcome

- VA managers agreed to take 24 administrative actions against high-ranking officials and 17 corrective actions to improve operations and activities as a result of these investigations. The corrective actions included directing officials to repay money due the Government and others, and reviewing or properly approving personnel-related matters.

Cost Effectiveness

- Administrative investigations closed during the reporting period were completed in an average of 25 staff days.

Timeliness

- The average time from receipt of an allegation to initiation of an investigative case, for all cases initiated during the reporting period, was 20 days. The average time from initiation of an investigative case to case closure (or issuance of a draft report), for all cases closed (or with draft reports issued) during the reporting period, was 54 days.

Customer Satisfaction

- The average rating on customer satisfaction surveys returned during the reporting period was 4.4 out of a possible 5.0 (5.0 represents the greatest satisfaction and 1.0 represents the least satisfaction).

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

Frequent Flyer and Other Travel Issues

An administrative investigation substantiated that a VISN Director did not properly account for frequent flyer miles he maintained in accounts containing both miles earned from official travel and miles earned from personal travel. The Director did not redeem any of these miles for free airline tickets in conjunction with official travel until he became aware of our investigation. The investigation also substantiated that the Director improperly acquired frequent flyer miles for his personal use by using a personal credit card to pay for reimbursable expenses while on official travel. By not using his Government charge card, he thwarted the purpose of the charge card program. The personal credit card earned frequent flyer miles that were deposited in his spouse's frequent flyer account. Finally, the investigation substantiated that the Director's spouse benefited from the use of some of these miles by using them for personal travel.

VHA concurred with recommendations to take appropriate administrative action against the Director; to come to a mutual agreement with him as to how many miles currently in his account belong to the Government and how many belong to him, and ensure that he maintains an accurate accounting of such miles in the future; and to direct him to redeem his miles for all future Government travel he and his staff take until his miles have been depleted. The investigation also substantiated that the director wasted Government travel funds by not always using the contract air carrier, improperly claiming reimbursement for lodging costs above the maximum allowance, renting automobiles unnecessarily, renting full-size automobiles without justification, and not obtaining hotel tax exemptions. In addition, the investigation substantiated that the Director improperly used a specific airline and rental car company to earn frequent flyer miles, and did not review or sign his travel vouchers.

VHA concurred with recommendations to take appropriate administrative action against the Director; issue him a bill of collection for the additional amount the Government spent for him to travel on another airline when a Government contract carrier was available; and require him to justify the excessive lodging costs he incurred, or issue a bill of collection for the amount improperly paid to him. VHA also planned to arrange for a full audit of the Director's travel vouchers for the past 5 years. *(Misuse of Frequent Flyer Miles and Other Travel Issues, VISN 7, Atlanta, GA, 99-01434-103, 7/12/01)*

Employee Relocation and Office of Workers' Compensation Programs Issues

An administrative investigation substantiated that a VAMC Director, Human Resources Management Service Chief, and Business Office Chief intentionally violated Federal regulations and VA policy regarding reimbursement of relocation expenses for employees transferring to the medical center's blind rehabilitation center. These officials authorized the transferring employees' reimbursement of some, but not all, of the expenses to which they were entitled. VHA concurred with recommendations to take appropriate administrative action against these officials, and to review the records of all employees who relocated to the facility since the director arrived, and pay all properly reimbursable relocation expenses incurred. VHA also planned to present this issue as a "lesson learned" for all VISN and medical center directors in the event the practice was in place at other locations.

The investigation further substantiated that the Human Resources Management Service Chief and Business Office Chief violated Federal regulations and VA policy by not reporting job-related injuries, or billing the associated costs, to the Office of Workers' Compensation Programs. The investigation could not conclusively determine the Director's role in this matter, but he was responsible for knowing what the medical center's practices were and taking steps to correct them, but did not. As a result of these violations, the medical center was not reimbursed for the cost of treating job-injured employees. VHA concurred with recommendations to take appropriate administrative action against the officials, and ensure that job-related injuries were appropriately reported and billed.

Finally, the investigation substantiated that the VAMC Director and Human Resources Management Service chief did not ensure that employees were adequately informed about their workers' compensation program entitlements, and that the director denied three employees continuation of pay benefits. VHA concurred with recommendations to take appropriate administrative action against the officials, and ensure that employees who were injured at the medical center since the Director arrived received all the benefits to which they were entitled. *(Irregularities in Employee Relocation Reimbursements and the Workers' Compensation Program, VAMC West Palm Beach, FL, 00-01632-117, 7/20/01)*

Misuse of Position and Other Issues

An administrative investigation substantiated that a VAMC Director improperly used his title and position to recommend a construction contractor seeking additional VA business to other VA facility directors. The investigation also substantiated that the Director did not ensure that an employee's vehicle accident claim was properly investigated before it was forwarded to regional counsel. VHA officials agreed to ensure the Director was aware of his responsibilities in these matters.

We also determined that approval of the vehicle accident claim may not have been appropriate. As a result of the investigation, the regional counsel reversed his earlier decision awarding the claim. Finally, the investigation substantiated a pattern of improper procurements of computer training services since November 1995. VHA agreed to take appropriate administrative action against the responsible employees. *(Misuse of Position and Other Issues, Jerry L. Pettis Memorial Veterans Medical Center, Loma Linda, CA, 00-01900-77, 5/22/01)*

Research Foundation and Employee Award Issues

An administrative investigation substantiated that a VAMC Director improperly used over $3,300 in funds from a VA-approved research foundation to

host two dinners for senior medical center staff, and misused his VA position to obtain benefits for himself and a relative. The research foundation had policies specifically prohibiting the use of its funds to pay for entertainment expenses at functions held exclusively for VA and foundation staff. VHA agreed to take appropriate administrative action against the Director, and to pursue options for the Director to reimburse the foundation for the cost of the dinners.
The investigation also substantiated that the Director and two other senior medical center officials improperly processed or approved cash awards for four senior managers in excess of the Director's delegated approval authority. VHA agreed to take appropriate administrative action and to review the four awards. *(Research Foundation and Employee Award Issues, VAMC Kansas City, MO, 01-00365-71, 5/4/01)*

Misconduct and Resource Misuse Issues

An administrative investigation substantiated that a VAMC Chief Operating Officer used disrespectful language having racial overtones when speaking to subordinates. The investigation also substantiated that the Chief Operating Officer possessed and served alcohol at the medical center during duty hours, and arranged to have several personal wall decorations framed at Government expense. VHA agreed to take appropriate administrative action against the Chief Operating Officer, and informed us that she agreed to reimburse VA for her personal framing expenses. *(Misconduct and Resource Misuse Issues, Ralph H. Johnson VAMC Charleston, SC, 01-00865-90, 6/18/01)*

Acceptance of Compensation and Gifts Issues

An administrative investigation substantiated that a Chief of Pharmacy improperly accepted remuneration from pharmaceutical company representatives for discussing with them subjects related to his official duties. VHA officials reassigned the Chief to a clinical pharmacist position, at a lower grade level, and told us the individual had repaid the compensation.

The investigation also substantiated that health care employees at the facility improperly accepted free meals from pharmaceutical companies at the facility and at local restaurants, with the knowledge of the Chief of Staff. VHA officials agreed to stop their practice of allowing pharmaceutical companies to provide free meals at the facility, and to provide ethics training to affected employees. They also planned to determine appropriate action to be taken against the Chief of Staff, and took action against another management official who solicited a pharmaceutical company to provide a meal for himself and other health care providers. *(Acceptance of Compensation and Gift Issues, VA Southern Nevada Healthcare System, Las Vegas, NV, 01-01008-131, 8/27/01)*

Misuse of Government Resources and Other Issues

An administrative investigation substantiated that a VHA Central Office senior official misused a Government laptop computer to access pornographic websites. VHA agreed to take appropriate administrative action against the official. The investigation also substantiated the official did not appoint an information security officer in accordance with VA policy. We recommended that the appointee's responsibilities be transferred to another appropriate individual. VHA concurred with the recommendation and was taking steps to fully implement the transfer of responsibilities. *(Misuse of Government Resources and Other Issues, VHA Office of Information, Washington, DC, 01-01062-115, 7/18/01)*

Various Issues

Advisory memoranda were issued to management officials, advising them of administrative investigation findings not warranting formal recommendations. For example, we informed the Under Secretary for Health that, several years earlier, a VISN made nearly $400,000 in furniture purchases, yet we found no documentation indicating the purchases were properly approved, or that the former Deputy Secretary was apprised of the cost, as he had requested. We also informed a VA Central Office official that a senior-level position within his organization had not been properly reviewed and approved, and informed a VISN director that his acquisition staff did not appropriately implement changes to the terms of a contract. Finally, we advised a medical center director that an open dialogue between management and physicians at the facility could alleviate concerns some physicians had about others regarding duties performed at the affiliated university. *(various unnumbered memoranda)*

Veterans Benefits Administration

Burial of Indigent Veterans Issue

An administrative investigation, conducted at the request of the Ranking Democratic Member of the House Committee on Veterans' Affairs, concluded that a VARO did not provide inaccurate veteran status information to the local county medical examiner. Local news reports indicated that the regional office did not identify three individuals as veterans, resulting in these individuals being buried in pauper's graves rather than a VA national cemetery. The investigation disclosed that local authorities did not contact the regional office to verify the decedents' veteran status until after they were buried, and that one of the three could not be identified as a veteran. Regional office officials initiated a comprehensive review of names of individuals buried in the county cemetery over the past 2 years, and identified two additional veterans. Regional office officials also initiated and signed an agreement with the county to ensure that the names of all age-appropriate persons, whose remains are unclaimed, are referred to the regional office to determine their veteran status. *(Burial of Indigent Veterans Issue, VA Regional Office, VBA, Chicago, IL, 01-02075-116, 7/24/01)*

Office of Human Resources Management

Employee Drug Testing Program Issue

An administrative investigation disclosed that Office of Human Resources Management officials in VA Central Office have not implemented random employee testing for illegal drug use, as required by an executive order and VA policy. The Assistant Secretary for Human Resources and Administration acknowledged more could have been done to expedite implementation of the program, which he said has been delayed due to unresolved union issues. In response to our recommendation to initiate such testing, the Assistant Secretary outlined a plan to expedite resolution of union concerns and, regardless of the outcome, at least partially implement the program. *(Employee Drug Testing Program Issue, VA Central Office, Washington, DC, 01-01893-127, 8/7/01)*

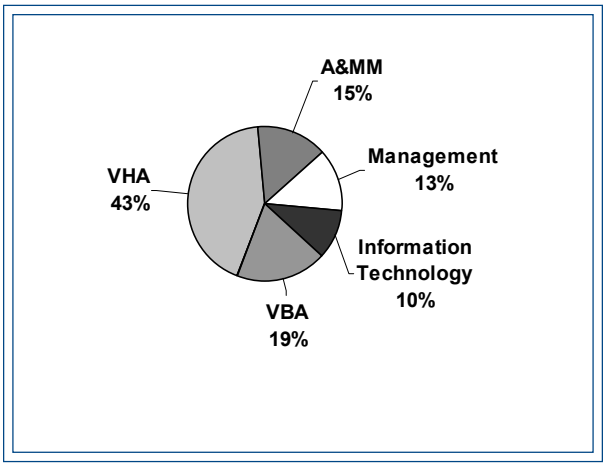
OFFICE OF AUDIT

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 has 166 FTE allocated for its headquarters and 8 operating divisions located throughout the country. 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 34 audits, evaluations, and reviews for an output efficiency of 1 report per 2.3 FTE during this 6-month period. We also issued an additional 20 contract review reports (7 preaward contract reviews and 13 postaward reviews), for an output efficiency of about 1 report per FTE for the 6-month period.

Outcome

- Recommendations to enhance operations and correct operating deficiencies have associated monetary benefits totaling $1.65 billion. In addition, contract reviews identified monetary benefits of $11.7 million associated with the performance of preaward and postaward contract reviews.

Cost Effectiveness

- We achieved a return of $150 in monetary benefits for every dollar spent on audits, evaluations, and reviews during this 6-month period. We also achieved a return of $10 in monetary benefits for every dollar spent on contract reviews. Additionally, contracting officers sustained 72 percent of our recommended better use of funds during negotiations.

Customer Satisfaction

- Customer satisfaction with performance and financial audits and evaluations during this reporting period was 4.0 on a scale of 5.0. The average customer satisfaction rating achieved for contract reviews was 4.6 out of a possible 5.0.

Audits completed during the period identified opportunities to improve services to veterans, and identified savings that could be used to increase services. The following summarizes some of the audits completed during the reporting period organized by VA component: VHA, Office of Management, and Office of the Secretary.

Veterans Health Administration

Resource Utilization

Issue: Availability of health care services in the Florida/Puerto Rico Veterans Integrated Service Network.
Conclusion: Inadequate capacity in some of the network's clinical services has restricted the availability of care to veterans.
Impact: Better use of $1.48 billion.

The audit examined the provision of health care services to veterans enrolled for medical care in VISN 8 in accordance with the VA medical benefits package. We found that the inventory of network clinical services provides enrolled veterans most of the services described in the medical benefits package. However, the network is unable to provide veterans with timely access to some of its clinical services because of clinic overcrowding. The network and its facilities are actively seeking solutions to the overcrowding of its clinics and the associated long waiting times that some patients experience.

The significant increases in patient enrollments experienced over the past several years, as well as the projected increases in future veteran enrollments without increased resources, will obstruct network and facility efforts to treat veterans more promptly. In the long-term, the network's efforts to improve clinic timeliness and reduce overcrowding require the modification of the VHA resource allocation strategy to include priority group 7 veterans in the Veterans Equitable Resource Allocation (VERA) funding distributions. This change would allow funding distributions for all networks to be based on the total number of veterans who receive care, and would be more closely aligned with the patient enrollment system.

We found that the budgetary impact of the increased priority group 7 enrollments to VISN 8 and VHA is significant. Improved network monitoring of clinical resource utilization and equity of resource distributions among its facilities would help reduce clinic overcrowding and excessive patient waiting times due to increasing workload. Including priority group 7 veterans in the VERA resource allocation formula could result in more effective funding distributions for care of these veterans to all of the 22 VISNs. This funding distribution is estimated to total $1.48 billion in FY 2001.

The VISN 8 Director concurred with the recommendations to address network clinic overcapacity issues and provided acceptable implementation plans. The Under Secretary for Health deferred responding to the recommendation to include priority group 7 veterans in the VERA system until other options are considered. The Under Secretary has requested that the Office of Policy and Planning establish a work group to fully study the issues of geographic means test/price adjustments and the impact on health care delivery to all veteran priority groups. We consider the recommendation unresolved until the results of the study are completed and specific implementation actions are provided that meet the intent of our recommendation. *(Audit of Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network (VISN) 8, 01-00057-55, 8/13/01)*

Issue: VAMC management of engineering supply inventories.
Conclusion: VAMCs could reduce large excess inventories by using automation, purchasing smaller quantities, and consolidating storage locations.
Impact: Better use of $168 million.

We performed an audit to evaluate how effectively VAMCs managed their engineering supply inventories. This was the fourth in a series of audits to assess VHA inventory management practices for various categories of supplies. In FY 2000, VAMC engineering supply purchases totaled $99 million. At any given time during FY 2000, the value of VAMC inventories was $230 million. VAMC engineering supply inventories substantially exceeded current operating needs. Our audit at five VAMCs with combined engineering supply inventories valued at $5.4 million found that $3.6 million (67 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. The recently issued VHA inventory management handbook requires VAMCs to use automated inventory systems to manage all categories of supplies. VAMC compliance with the new handbook should address most of the problems identified during the audit. However, we identified two inventory problems that were particular to engineering supplies: (i) VAMCs made unnecessarily large purchases of engineering supplies, which increased the risk the supplies might never be used; and (ii) VAMCs stored supplies in too many locations, which made it impossible to effectively manage inventories.

To further improve VAMC management of engineering supply inventories, we recommended that VHA encourage VAMCs to: (i) avoid unnecessarily large quantity purchases and, when feasible, make more use of small quantity purchases from local suppliers; and (ii) minimize the number of engineering supply storage locations. We estimated that better management could reduce VHA-wide engineering supply inventories by $168 million. The Under Secretary for Health concurred with the recommendations and provided acceptable implementation plans. *(Audit of VA Medical Center Management of Engineering Supply Inventories, 99-00192-65, 4/4/01)*

Issue: Treatment of non-veterans at VAMC San Juan, Puerto Rico.
Conclusion: The VAMC provided health care services to non-veterans that were not in accordance with VA policies.
Impact: Better use of $137,000.

We conducted a review of health care services provided to non-veterans at the request of the Director, Florida/Puerto Rico VISN 8. The Network Director was concerned that care was being provided to non-veterans under the auspices of humanitarian and employee care, and that the facility had not established appropriate sharing agreements. The review also focused on two other areas of concern involving VA physicians who were alleged to be using VA resources to further their private practices, and the appropriateness of payments made to a private health care provider; however, our review did not substantiate these two issues.

We confirmed VAMC San Juan did not follow VHA directives when it provided humanitarian and medical services to non-veterans. Services were inappropriately provided to non-veterans under health care agreements negotiated directly with third party insurers and reported by the facility as either humanitarian or reimbursable care. The review also found the VAMC inappropriately provided non-emergency, non-job related medical

services to employees. Controls over employee health care services at the facility have historically been weak.

We also found the VAMC needed to strengthen controls over billings for Department of Defense (DoD) health care services. Our review of billings for health care services provided under sharing agreements with DoD disclosed 175 instances where the facility's clinics provided treatment, but did not refer the cases to the finance office for billing. We estimate these services, if billed, would total approximately $137,000. The VISN 8 Director agreed with the report recommendations and provided appropriate implementation actions. *(Review of Treatment of Non-Veterans at VAMC San Juan, PR, 01-00759-69, 5/18/01)*

Program Management

Issue: Enhanced health care resources sharing authority.
Conclusion: Strengthened controls in the sharing agreement program will ensure maximum revenue generation while protecting VA's interests.
Impact: Improved management and operations.

We evaluated VHA enhanced health care resources sharing authority (sharing agreements) used to sell health care resources and services. Public Law 104-262, October 9, 1996, greatly expanded the scope of VA's sharing agreement authority. The legislation allowed VA to use its sharing agreement authority to sell VHA health care and administrative resources to public and private non-DoD sharing partners. During FY 1999, VHA reported selling over $35 million in services and resources to non-DoD sharing partners.

We conducted a detailed telephone survey of the sharing agreement process and reviewed 1 sharing agreement from each of the 10 VHA facilities that reported the highest sharing agreement revenues during FY 1999. We found that VHA needed to strengthen management controls and oversight to ensure that VA reimbursements were reasonable and interests were protected.

We concluded that strengthened management controls in the sharing agreement program will ensure the program maximizes revenue generation while also benefiting veterans and protecting VA's interests. During our evaluation, VHA issued VHA Directive 1660.1 and the Office of Financial Policy issued Bulletin 01GC2.03 to address weaknesses in the sharing agreement program's management and oversight. Therefore, we are making no recommendations at this time. However, we may revisit this subject after policy changes have been in operation long enough to fully assess their effectiveness. *(Memorandum Report, Evaluation of Enhanced Health Care Resources Sharing Authority, 00-02772-105, 8/30/01)*

Issue: VA Enhanced-Use Lease (EUL) program.
Conclusion: EULs provide a cost-effective way to use undeveloped or underutilized property to generate revenues, defray costs, and benefit veterans.
Impact: Enhanced revenues.

Public Law 102-86 enacted August 14, 1991, authorized VA to lease undeveloped or underutilized property for compensation in the form of cash and/or in-kind considerations. The law required EULs to contribute to VA's mission, enhance the use of VA property, and provide VA with fair compensation.

We reviewed 5 of the 17 EULs in effect as of December 1, 2000. The five EULs were implemented between August 1993 and December 1999, and included leases to construct housing for the homeless, a child development center, a

colocated VARO, and an energy cogeneration plant; there was also one agreement to lease out a VAMC golf course.

We determined the program operated effectively with adequate management oversight. In addition, VA is currently drafting policy changes that will streamline the process. Based on our evaluation, we concluded that EULs provided VA with a cost-effective way to use undeveloped or underutilized property to generate revenues, defray operating costs, and benefit veterans. However, we may revisit this subject after VA's policy changes designed to streamline the process are implemented and in operation long enough to fully assess their effectiveness. *(Memorandum Report, Evaluation of the VA Enhanced-Use Lease Program, 00-02773-106, 7/13/01)*

Issue: VA centralized means test pilot program evaluation.
Conclusion: Health Eligibility Center (HEC) needs to improve internal controls.
Impact: Assuring program integrity.

The HEC requested the OIG conduct an evaluation of the income verification pilot program to ensure internal controls provide adequate assurance that VA has appropriately signed means tests of record for income verification matching with the IRS and SSA. The HEC proposes to match calendar years (CYs) 1999 and 2000 means tests records for veterans receiving care at VAMCs located in VISN 1 and in North Carolina. The CY 2000 records the HEC plans to match also include means tests imaged to the HEC by VAMC Memphis.

We reviewed records randomly selected from the HEC CY 1999 and 2000 pilot program databases to verify that all records were supported by signed means tests on file at the HEC. We determined that 98 percent of the records in the CY 1999 database sample and 100 percent of the records in CY 2000 database sample were supported by signed means tests. In our opinion, the degree of accuracy found provides reasonable assurance that the HEC has signed means tests for the cases they plan to match for CYs 1999 and 2000. However, two CY 1999 means tests were not signed; four were signed by someone other than the veteran, but the HEC had no evidence that the person reporting the veteran's income was the veteran's legal representative. We also found that 10 CY 1999 means tests and 5 CY 2000 means tests were not dated.

We recommended that the HEC improve controls to ensure that means tests are signed and dated by the veterans or their legal representatives, and that the HEC maintains documentation supporting the authority of representatives to sign on behalf of the veterans. The Under Secretary for Health concurred with the findings and recommendations and stated that VHA is in the process of determining from legal counsel who may legally sign a means test on behalf of veterans. When the legal opinion is received, the recommendations will be implemented through appropriate policy and software modifications. However, clarification as to who may legally sign a means test on behalf of veterans is also a matter of negotiation between the IRS and VHA. The Under Secretary should ensure the IRS accepts the opinion before making any final changes to the process. *(Evaluation of the Department of Veterans Affairs Health Eligibility Centralized Means Test Pilot Program, 00-02165-119, 8/1/01)*

Office of Management

VA's Consolidated Financial Statements

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

The independent public accounting firm Deloitte & Touche LLP performed VA's Consolidated Financial Statements (CFS) audit for the OIG. As part of the audit, we issued six management letters addressing financial reporting and control issues. The management letters provided VA managers additional observations and advice that will enable the Department to improve accounting operations and controls.

One management letter: (i) reiterates the five reportable conditions, including two material weaknesses, identified in our previously issued CFS audit report No. 00-01702-50 (Audit of the Department of Veterans Affairs Consolidated Financial Statements for FYs 2000 and 1999, February 28, 2001); (ii) discusses three other matters also included in the report; and (iii) provides eight additional observations and recommendations from the audit to further assist the department in improving internal controls and financial reporting. The management letter also shows the results of the follow up of prior year CFS audit findings.

The other five management letters discuss automated data processing control and security at VA data processing centers. The contractor and OIG staff continue to work with VA staff on these issues as we proceed on the audit of VA's FY 2001 CFS. *[(i) Management Letter: Audit of VA's CFS for the Year Ended September 30, 2000, 00-01702-91, 6/26/01;*
(ii) Management Letter: Audit of VA's FY 2000 Consolidated Financial Statements General Computer Controls Review at VAMC Bay Pines, FL, 00-01702-96, 6/26/01;
(iii) Management Letter: Audit of VA's FY 2000 Consolidated Financial Statements General Computer Controls Review at Austin Automation Center, 00-01702-97, 6/22/01;
(iv) Management Letter: Audit of VA's FY 2000 Consolidated Financial Statements General Computer Controls Review at Philadelphia Benefits Delivery Center, 00-01702-98, 6/26/01;
(v) Management Letter: Audit of VA's FY 2000 Consolidated Financial Statements General Computer Controls Review at Hines Benefits Delivery Center, 00-01702-99, 6/26/01; and
(vi) Management Letter: Audit of VA's FY 2000 Consolidated Financial Statements General Computer Controls Review at VAMC Martinsburg, WV, 00-01702-100, 6/26/01]

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

Correction is in-process for items shown in our report on VA's consolidated financial statements as being noncompliant with Public Law 102-208 requirements. VA has taken a number of steps to establish a comprehensive information system security program. The Department's target completion date is FY 2003. Corrective action was substantially completed on housing credit assistance program financial system noncompliance items reported in our report on VA's FY 1999 consolidated financial statements.

In our report on VA's FY 2000 consolidated financial statements, we added one new item - noncompliance with OMB financial management

system requirements. VA is in the process of developing and testing a replacement core financial management and logistics system. Roll-out of the new system is scheduled to begin April 2003.

Regarding previously reported noncompliance with managerial cost accounting requirements, VA's National Cemetery Administration completed testing and converting system data during FY 2000 and will be fully implemented in FY 2003. VHA's target implementation is expected to be in FY 2002, permitting the cost system to be modified to include allocated costs such as accrued annual leave and judgment fund costs.

Preaward Contract Reviews

Issue: Federal Supply Schedule (FSS) vendors' best prices.
Conclusion: Vendors can offer better prices to VA.
Impact: Potential better use of $5.9 million.

- Preaward reviews of a diagnostic test kit and reagent manufacturer's offer resulted in potential savings of $4.9 million.

- Preaward reviews of two medical equipment and supply companies' offers resulted in potential savings of $1 million.

Issue: Health care resource contracts.
Conclusion: VA can negotiate reduced contract costs.
Impact: Potential better use of $1.6 million.

We completed reviews of four proposals involving scarce medical specialists' services. We concluded that the contracting officer should negotiate reductions of $1.6 million to the proposed contract costs.

Postaward Contract Reviews

Issue: Contractor overcharges for pharmaceuticals and medical supplies.
Conclusion: Postaward reviews and surveys disclosed overcharges.
Impact: Recovery of $4.2 million

- We completed four reviews of pharmaceutical manufacturers' contractual compliance with specific provisions of their FSS contracts. Recoveries amounted to $4.1 million.

- We completed one review of a medical supply manufacturers' contractual compliance with specific provisions of their FSS contract. Recovery amounted to $105,000.

- We completed four Public Law 102-585 compliance reviews at pharmaceutical companies, with recoveries amounting to $40,000.

Office of the Secretary

Issue: Management of VA acquisition process.
Conclusion: VA needs to improve buying practices.
Impact: Better use of funds.

Preparation of this report followed a discussion between the Secretary and the IG regarding the management of VA's acquisition process. The OIG performed an analysis of data obtained during various OIG reviews relating to: (i) vendors selling medical/surgical supplies and equipment, (ii) vendors selling pharmaceuticals to VAMCs, and (iii) the purchasing practices employed by VAMCs. Our analysis of VA's open-market buying and contracting practices, and our review of commercial buying and selling practices, has led us to the conclusion that VA is not leveraging its purchasing power through prudent acquisition

practices to obtain best prices considering the volume of items purchased.

As a result of making FSS contracts non-mandatory sources of supply, there has been an increase in open-market purchases by VAMCs, often without attempts by the centers to either negotiate prices or determine price reasonableness. The term "open-market" describes the purchase of goods and services that are not on contract. In increasing numbers, vendors have: (i) withdrawn high-volume medical supply items from FSS contracts, (ii) refused to negotiate in good faith, (iii) cancelled contracts, or (iv) not submitted proposals for FSS contracts. Notwithstanding the fact that these vendors no longer have contracts, they have not lost their VA market share because they continue to sell in large volumes to individual VAMCs. In addition, they can sell products made in non-designated countries directly to VA facilities that they cannot sell on FSS or other contracts because of the Trade Agreements Act requirements. Also, our review of purchase card records, invoices, purchase orders, procurement history files, and other related records, lead us to believe that VHA is purchasing open-market health care items in amounts greater than the 20-percent maximum allowed under Title 38 U.S.C. §8125(b)(3)(A). These conditions are a result of the widespread and essentially unmonitored, use of purchase cards in conjunction with the decentralization of purchasing authority to VA medical centers.

To alleviate these conditions and improve VA's buying practices, we believe VA management should consider the following: (i) that VA facilities be required to purchase items that are on national contracts, such as FSS, and that the FSS and other national contracts be mandatory sources of medical/surgical supplies and equipment and pharmaceuticals unless otherwise determined by the Department's Procurement Executive; (ii) that local contracts be specifically prohibited unless authorized by the Department's Procurement Executive or designee; (iii) that VA implement a program to monitor local purchasing and hold local officials accountable for not complying with provisions in the Veterans Administration Acquisition Regulations and Federal Acquisition Regulations; and (iv) that policy be made limiting contracts with distributors to distribution services only, unless the distributor can show that it is responsible for negotiating and establishing prices for items it distributes to the manufacturers' commercial customers. *(Evaluation of the Department of Veterans Affairs Purchasing Practices, 01-01855-75, 5/15/01)*

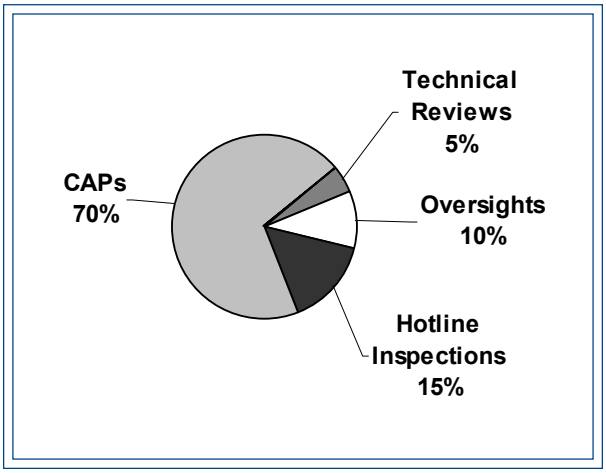
OFFICE OF HEALTHCARE INSPECTIONS

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.

Resources

The Office of Healthcare Inspections (OHI) has 34 FTE allocated to staff headquarters and field operations. The following chart shows the allocation of resources utilized in inspecting each of VA's major health care areas.



Overall Performance

Output

Inspectors completed 242 initiatives this reporting period.

- We participated in 16 CAP reviews, evaluated 115 health care related issues, and developed 92 recommendations to improve operations and activities, and the care and services provided to patients.

- We completed 15 Hotline cases, reviewed 38 issues, and developed 74 recommendations to correct conditions identified and improve the care and services provided to patients.

- We monitored the completion of another 162 Hotline cases by VHA, reviewed 475 issues, and assessed, based on the evidence VHA presented, their plans to implement 126 recommendations intended to improve the quality of care and services provided patients. Of these 162 cases, we requested additional information on 45 VHA responses (28 percent) because not all of the issues were addressed or satisfactorily resolved.

- We provided clinical consultative support to investigators on six criminal cases.

- We followed-up on recommendations made at four medical centers to ensure managers acted on their implementation plans to improve care and services.

- We completed 37 technical reviews on recommended legislation, new and revised policies, new VA program initiatives, and external draft reports.

- We oversaw the work of the Office of the Medical Inspector on one project and consulted with the Office of Research Compliance and Assurance on one project.

Outcome

- Overall, we made or monitored the implementation of 292 recommendations to improve the quality of care and services provided to patients and their families. VHA implementation plans will improve clinical care delivery, management efficiency, patient safety, and employees' accountability for their actions.

Veterans Health Administration

Healthcare Inspections (Hotline Cases)

Issue: End-of-life care in the nursing home care unit (NHCU).
Conclusion: VHA policies were not followed and standards of care were not met.
Impact: Improved procedures, clinician training, and standards.

We reviewed the adequacy of end-of-life care provided to a patient in the VA facility NHCU. We substantiated the allegation that clinicians' actions in this case were not consistent with VHA regulations and the standards of care were not met. Caregivers did not provide oral food and fluids to a patient who was capable of consuming food and fluids when fed. Although VHA policy allows for withdrawal of "life sustaining treatment," it does not permit withholding oral food and fluids from a patient.

As a result of the inspection, the facility Director: (i) strengthened health care system policies for end-of-life care, including the withholding of oral foods and fluids; (ii) examined and strengthened the facility's bio-ethics advisory committee's function in advising clinicians and administrative employees; (iii) assessed the responsible clinicians' conduct and took administrative actions; and (iv) strengthened procedures for overseeing the competencies of sitters hired by families to work with patients. *(End-of-Life Care Issue, VA Palo Alto California Healthcare System, Palo Alto, CA, 00-01293-42, 4/26/01)*

Issue: Appropriateness of care provided to a VA patient in a medical emergency.
Conclusion: Standard of care was not met.
Impact: System improvements taken to respond to medical emergencies.

A complainant alleged that an inpatient died as a result of a clinician's refusal to appropriately care for the patient before or during his collapse and unsuccessful resuscitation. We found that the standards of care were not met in this case and recommended corrective actions.

The Director concurred and had already begun taking administrative action and making several systems improvements. Administrative actions were initiated, pulse oximeters were placed on all wards, and employees received training on using aerosol bronchodilators and how to respond to and document medical emergencies. Managers also revamped procedures to improve response times and use of the overhead paging system. *(Healthcare Inspection - Quality of Care Provided to a Patient, VA Gulf Coast Veterans Health Care System, Biloxi, MS, 00-02729-94, 7/3/01)*

VA Gulf Coast Veterans Health Care System
Biloxi, MS

Issue: Contract nursing home placement and follow up coordination.
Conclusion: Standard of care was not met and a patient was lost to VA clinical oversight.
Impact: Pending legal actions and enhanced coordination between VA facilities.

Senator Christopher Bond's staff asked us to review an allegation that a patient discharged from the VAMC and placed in a contract nursing home did not receive adequate care at the contract facility. At the time of discharge to the contract nursing home, the patient was clinically stable and agreeable to the placement. However, VA clinical managers concluded that the standard of care was not met at the contract nursing home because of lapses in documentation about the patient's condition, and the excessive time it took to provide the patient with urgent medical care. We agreed with the VA facility's findings. The family subsequently chose to pursue legal action against the contract nursing home. In addition, the VA voided the community nursing home national contract.

We also noted that because of the distance between the originating VA facility and the contract nursing home, the patient's follow up should have become the responsibility of a VA facility nearer to the site. However, requisite communication between social work service employees at the VA facility out-placing the patient and VA facility nearer to the contract nursing home never occurred, and the patient was lost to VA clinical oversight. The originating medical center's Director acted to improve discharge planning and placement procedures at the VA facility, and coordination and follow up efforts among area medical centers. *(Allegation of Wrongful Death in a VA Community Contract Nursing Home, 01-00787-81, 6/1/01)*

Issue: Patient abuse.
Conclusion: Managers' inaction contributed to the loss of medical evidence needed to determine whether the patient was abused.
Impact: Strengthened procedures and controls to improve patient safety.

The Chairman of the Senate Committee on Veterans' Affairs and the VHA Office of Medical Inspector asked that we review an allegation that a patient was abused while he was hospitalized at a VA facility in 1998. The patient asserted that an employee hit him in the eye resulting in permanent lost of sight in his left eye. We found that: (i) the patient sustained an injury to his left eye after his admission to the VA facility, leading to the inability to see out of his eye; (ii) the Director should have, but did not conduct an administrative investigation of the issue at the time of the injury; and (iii) the patient and family were not informed of available options for possible compensatory damages as required by VHA policy. Managers' inaction contributed to the loss of medical evidence needed to investigate the case adequately.

VA Medical Center
Danville, IL

We made three recommendations to strengthen procedures and controls for improving patient safety, and informing the family of their options in this case. The Director concurred with the recommendations and provided responsive action plans. *(Alleged Patient Abuse, Veterans Affairs Medical Center Danville, IL, 01-00119-110, 7/30/01)*

Issue: Quality of care and services, management issues, and timely access to care.
Conclusion: Managers needed to focus on improving the quality of care and services, management oversight, and reducing waiting times in clinics.
Impact: Strengthened transfer policies, improved quality and prosthetic services, and timely access to outpatient care.

Senator Phil Gramm's office asked us to review allegations of complaints alleging clinical deficiencies and mismanagement. There was some evidence to show that VA clinicians might have had a patient transferred from a non-VA hospital burn center back to the VA facility prematurely. We did not feel it was prudent to transfer the patient, therefore we asked VHA senior officials to intervene, and they provided us assurances that the patient received adequate care. We also found that employees did not consistently issue medical items to eligible patients, and VISN managers ensured the Director acted to address this issue and clarify related policies and procedures. We found that the VA facility did not

West Texas VA Health Care System
Big Spring, TX

have a prescribed process for providing clinical support to Hoptel guests needing medical assistance, and VHA improved controls, processes and procedures to address this issue. VHA also acted to review the appropriateness of privileges provided to a clinician, and responded to realign and provide the VA facility additional staffing support to reduce long waiting times in primary care and specialty clinics identified during this review. *(Patient Care and Management Issues at the West Texas VA Health Care System, Big Spring, TX, 00-00986-80, 5/21/01)*

Issue: NHCU environment.
Conclusion: Physical plant, sanitation, and safety deficiencies need attention.
Impact: Improved quality and safety for patient residing in the NHCU.

We substantiated allegations concerning the NHCU patient care environment including that: (i) the air conditioning system was not operating effectively; (ii) several areas of the NHCU and various equipment items were badly soiled, and refrigerators contained outdated food and were dirty; (iii) an exit door alarm to protect wandering patients was malfunctioning; and (iv) the patients and the rooms they occupied were not adequately identified. In addition, not all patients had adequate supplies of drinking water at their bedsides. The Director acted to improve the quality of care, sanitation, and patient safety issues. *(Treatment of Patients in Nursing Home Care Unit (NHCU) at the Department of Veteran Affairs Medical Center Philadelphia, PA, 00-02759-128, 8/14/01)*

Issue: Thirty allegations received.
Conclusion: Managers needed to resolve numerous issues.
Impact: Improved access to care, quality of care and services, safety, and tracking bed use.

We received more than 30 allegations from numerous complainants. We concluded that managers needed to confront and resolve numerous issues at the VA facility. As the result of the inspection, the Director: (i) completed a peer review of the quality of care provided to a patient; (ii) implemented procedures to identify and track "near misses"; (iii) reexamined sharing agreement

partner obligations; (iv) followed-up on long outstanding pain clinic consultations; (v) educated applicable employees about the availability of and protocol for the new pain clinic; (vi) ensured contracts delineated the process for reporting abnormal test results; (vii) ensured Radiology Service employees developed a pre-screening process to improve timeliness of magnetic resonance imaging appointments; (viii) developed a system to reduce delays in providing verified test results to treating physicians; (ix) ensured that radiology service managers developed and implemented a system to monitor quality and timeliness of service; (x) ensured the VA facility's satellite outpatient clinic contract stipulated that all security guards are physically capable of intervening in emergency situations; and (xi) improved the tracking and monitoring of bed utilization. *(Patient Management at VA Gulf Coast Veterans Health Care System, Biloxi/ Gulfport, MS, 00-01535-43, 4/9/01)*

"The OIG has been consistently helpful and responsive. We have improved patient care significantly as a result of their findings and recommendations."

Director
VA Gulf Coast Veterans Health Care System

Issue: Access to care.
Conclusion: Patients were not denied care, but better bed use among area facilities was needed.
Impact: Improve procedures for controlling patient admissions and transfers.

A complainant alleged that managers inappropriately denied medical care to a number of patients and transferred them to private Chicago area health care facilities where they received inadequate care. We did not confirm that patients were denied care or received inadequate care. However, we found that patients were diverted to other VA and non-VA facilities when the VA hospital was at inpatient capacity and did not have available beds, and that current procedures most likely caused some inconveniences to patients.

The Director agreed to strengthen the facility's bed utilization program, work with area managers to establish a proactive VISN-wide bed resource system, develop procedures to more effectively monitor and track patients who are diverted or transferred to other facilities, and develop definitive policies and procedures that address bed availability and how bypass status is determined and implemented. *(Healthcare Inspection - Alleged Denial of Medical Care to Patients, Edward Hines Jr. VA Hospital, Hines, IL, 00-01383-82, 7/16/01)*

Issue: Research improprieties.
Conclusion: Original consent forms were not in patients' medical records.
Impact: Strengthened research consent policy and improved quality.

Complainants alleged that the Chief, Research Section: (i) conducted research on patients without appropriately notifying the health care team of the protocol and did not place informed consents in the medical records; (ii) did not use sound clinical judgment in the treatment of six patients; and (iii) discontinued grand rounds and omitted home care staff from discharge planning rounds. We did not confirm that the chief failed to use sound clinical judgment in treating the six patients. However, we substantiated that the chief had discontinued rounds and omitted home care employees from discharge planning rounds. We also noted that original consent forms were not always in the patients' medical records. The Director concurred with our recommendations and provided acceptable implementation plans. *(Alleged Research Improprieties and Quality of Care Issues, Department of Veterans Affairs Medical Center Miami, FL, 01-00519-118, 7/26/01)*

Issue: Adequacy of surgical and inpatient care.
Conclusion: Care was consistent with the standards at the time.
Impact: Improvements in documentation, procedures, and communication.

We reviewed the adequacy of two episodes of care provided to a patient at the facility. We assessed the adequacy of a cataract excision and intra-ocular lens placement procedure and the adequacy of the care provided 3 months before the patient's death in July 1995. We concluded that for both treatment episodes, the physicians provided care that was consistent with the standards at the time. Managers acted to resolve documentation, procedural, and communication problems identified as the result of their own peer review in this case. *(Patient Care Issues at the VA Greater Los Angeles Health Care System, 00-00525-30, 4/3/01)*

Issue: Quality of care and services to domiciliary patients.
Conclusion: Managers acted to improve the quality of care and services.
Impact: Improved programs, cleanliness and safety.

In November 1999, we conducted a review and found various deficiencies related to the post-traumatic stress disorder and domiciliary programs, the domiciliary physical environment, clinical staffing, employee satisfaction, and internal controls that required corrective actions. We made eight recommendations to improve or enhance programs and operations. The Director concurred with our recommendations and submitted responsive action plans. The purpose of this follow up review was to determine the status of action plan implementation and effectiveness of completed corrective actions in selected areas.

Carl Vinson VA Medical Center
Dublin, GA

We concluded that medical center managers had made significant improvements in programs and operations. The medical records review workgroup was actively evaluating medical record deficiencies. The domiciliary wards were generally clean and reasonably maintained. We observed construction and maintenance activities and accepted the Director's established plan to renovate additional domiciliary wards as funds become available. The domiciliary program structure had been redesigned to more appropriately support therapeutic programs, and performance improvement activities. The post-traumatic stress disorder clinical team had been reorganized and reflected a higher degree of structure and continuity.

Additionally, it appeared that nurse-staffing concerns were being properly addressed, and an innovative plan for recruitment and retention was being pursued. As an apparent result of improved communication efforts among managers and employees, grievances decreased in FY 2000. Medical center managers had properly responded to the recommendations and implemented the actions outlined in their action plans, resulting in noticeable improvements in many areas. Managers also agreed to implement several suggestions we made to further improve programs and operations. *(Combined Assessment Program Review Follow Up, Carl Vinson VAMC Dublin, GA, 00-00358-58, 5/14/01)*

Issue: Management of intravenous access sites (heplock care).
Conclusion: Facility had no written policy or procedure for care and maintenance of heplock sites.
Impact: Better controls to ensure proper management and documentation.

The complainant alleged that clinicians failed to manage his intravenous access site (heplock), an intern treated him improperly, his hospital bathroom was unsanitary, and his medical records contained false information. Medical center managers responded adequately to all but one of the issues, that of heplock management. The Director agreed to strengthen controls and issue policies and procedures on managing and caring for intravenous access sites. *(Alleged Medical Treatment Issues at the Department of Veterans Affairs Palo Alto Health Care System, 00-02885-92, 6/21/01)*

Issue: Quality of care provided to patients on the extended care unit.
Conclusion: Patients needed to engage in daily living activities.
Impact: Better quality of life for patients.

Complainants alleged that nursing employees did not assist a Parkinson's disease patient with his meals, and did not adequately treat the patient after he lost control of his bladder and bowel and soiled his clothes. Also nursing employees did not help other extended care unit patients with their meals. We did not substantiate any of the allegations. However we found that employees needed to improve procedures to: (i) ensure that extended care unit patients who are able, eat their meals in the dining room; (ii) the treatment plan and recommended feeding method for the Parkinson's disease patient is followed; and (iii) employees develop a routine schedule of activities for extended care patients. The Director concurred with the recommendations and provided acceptable action plans. *(Quality of Care Provided to Patients in the Extended Care Unit, Department of Veterans Affairs Medical Center Dayton, OH, 00-02987-109, 7/16/01)*

Issue: Patients affected by unscheduled operating room closure.
Conclusion: Managers made appropriate arrangements during temporary closure.
Impact: Enhanced communication between management and clinicians.

An anonymous complainant alleged that two patients experienced abuse as a result of the operating room suite closure. We did not substantiate the allegation. The operating room was closed for needed facility upgrades and repairs, but managers made appropriate arrangements for the provision of surgical services through other area VA facilities. We did find that

Edward Hines, Jr. VA Hospital
Hines, IL

the emergency department director and employees were not adequately informed of the closure. We recommended the Director implement measures to ensure that similar communications lapses that may affect emergency patient dispositions and treatment decisions do not recur. The Director concurred with the recommendation and provided acceptable implementation plans. *(Alleged Patient Abuse Due to the Closure of the Operating Room, Edward Hines, Jr. Veterans Hospital, Hines, IL, 00-01383-126, 8/7/01)*

Issue: Unauthorized treatment for gender identity disorder (GID) patients.
Conclusion: Patients received unauthorized gender-altering services.
Impact: Better understanding of policies on the provision of GID services.

Employees alleged that managers inappropriately approved: (i) treatments for GID patients, (ii) prosthetics equipment for GID patients, and (iii) a GID-related research study. We confirmed that patients received gender-altering services, and substantiated the allegation that GID patients received prosthetic equipment in a manner that was not consistent with VA policy. We did not substantiate the allegation that managers inappropriately approved a GID research study. The Director took action to educate clinicians and participants of VHA's policy restrictions on providing GID-related health care, and strengthened prosthetic service controls for monitoring and following-up on equipment that is issued on a temporary basis. *(Healthcare Inspection - Gender Identity Disorder (GID) Services for Patients at the James H. Quillen Veterans Affairs Medical Center, Mountain Home, TN, 01-00223-111, 8/30/01)*

Healthcare Inspections (Oversight Inquiries)

During the reporting period, OHI oversaw the completion of 162 Hotline cases referred to VHA for action. Of these cases, 475 allegations were addressed of which 361 were not substantiated (76 percent) based on the evidence presented by VHA. The remaining 114 allegations had merit based on the information available, and VA managers acted to create new or strengthen existing procedures, take administrative actions, offer more education and training, improve quality of services, strengthen patient safety, enhance the physical plant environment, and realign resources. In addition, our oversight efforts found that of the 162 cases reviewed, 45 cases (28 percent) required further review by VHA managers to satisfactorily respond to all issues. In these 45 cases, we contacted VA facilities quality managers and worked with them until all issues were resolved, or we returned the cases to VHA senior managers for higher-level review.

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 review.

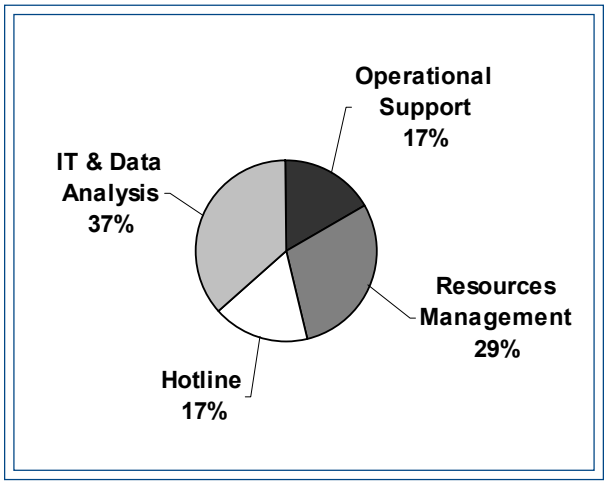
II. Operational Support Division - The Division does follow up tracking of OIG report recommendations; Freedom of Information Act releases; strategic, operational, and performance planning; and IG reporting and policy development.

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.

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 52 FTE allocated to the following areas.



I. HOTLINE DIVISION

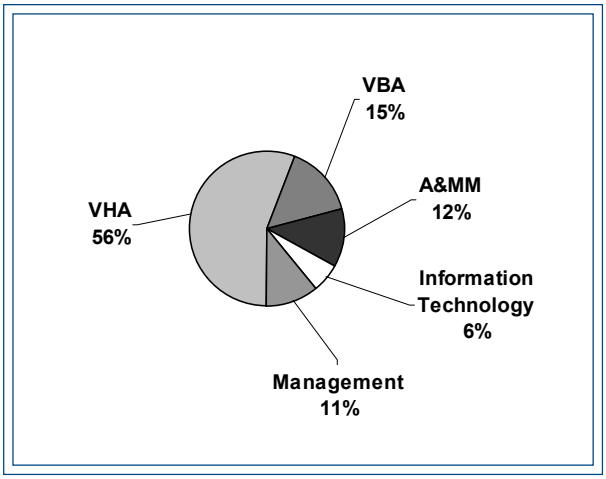
Mission Statement

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 5 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, U.S. 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 nine FTE staff positions. The following chart shows the estimated percentage of resources devoted to various program areas.



Overall Performance

During the reporting period, the Hotline received 8,324 contacts. Of this number, 650 cases were opened. The OIG reviewed 168 (26 percent) of these and the remaining 482 cases were referred to VA program offices for review.

Output

- During the reporting period, Hotline staff closed 630 cases, of which 181 contained substantiated allegations (29 percent). The Hotline staff generated 104 letters responding to inquiries received from members of the Senate and House of Representatives.

Outcome

- VA managers imposed 59 administrative sanctions against employees and took 73 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled $888,728.

The Hotline Division's most significant leads are referred to other OIG elements. The 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

Quality of Care

- In response to a Hotline inquiry, an investigation by the VHA Office of the Medical Inspector found that a veteran's treatment for bladder cancer was delayed. Although the veteran was held responsible for this delay because he refused to be treated by residents, the Office of the Medical Inspector reviewers were concerned that the veteran's request resulted in the delay in treatment of a serious condition. This matter was referred to the medical center's ethics committee for consideration.

- A VHA review at a VAMC substantiated an allegation of employee disrespect to patients. Since this was the second such occurrence by the employee, management proposed termination. Additionally, the VHA review substantiated an allegation of unnecessary pre-operative tests because the tests had previously been completed at other VAMCs and the diagnostic results could have been obtained from the other facilities. As a result, the clinical affairs associate director will reiterate the policy of accepting diagnostic results from other VAMCs.

- A VHA review found excessive waiting times in a VAMC's neurology clinic. In response to the high demand for services, the facility is currently recruiting for a part time neurologist. Neurological services will also be offered at their community based outpatient clinic. Additionally, the primary care staff is being educated on the proper procedure for referrals to specialty clinics.

- A VHA review found that an outpatient clinic was experiencing staff shortages because of significant physician turnover. The VAMC initially anticipated being able to absorb the workload into the schedules of physicians who remained. However, management has since reassessed this position and increased efforts to recruit additional staff and negotiate contracts with the affiliated university to provide services.

- A VHA review found there was a 21-minute delay in transporting a work therapy grounds employee to the VAMC for treatment. The review revealed the employee was suffering from what appeared to be a seizure or a diabetic episode, and the station bus driver who assisted the employee did not follow established procedures for notifying the facility about the employee's medical emergency. Management has reissued a station memorandum on emergency medical responses on facility grounds to all division managers for review with all employees.

- A VHA review found a lack of supervision by attending physicians in the intensive care unit. The attending physician involvement was not routinely documented for 30 percent of the unit patients. The chief of staff met with each specialty director to reinforce the requirement that daily involvement in the care of critically ill patients must be documented without exception, and recommended to the clinical executive board that the attending physician must co-sign all unit progress notes.

- A VHA review found the issuance of an incorrect medication and poor communications with a patient. The patient was issued an oral rather than a nasal inhaler. Additionally, the pharmacy filled a partial prescription for the veteran, but neglected to run an extra medication label for the balance of his prescription order. The VAMC has taken corrective actions to reduce the chance of future errors. The pharmacy supervisor corrected the error and the veteran was issued the balance of his prescription refill.

- A VHA review found a work incentive program that had been promised to participants of a methadone clinic by the end of 2000 had not been established. The review also found some consult

referrals to primary care or specialty clinics had not resulted in appointments. As a result, implementation of the work incentive program has been assigned to the new mental health service line director and new appointments have been scheduled.

- A VHA review found a veteran was abusing her fee-basis eligibility and obtaining excessive quantities of narcotic drugs from a VAMC. As a result, the veteran's fee-basis care eligibility was terminated and she is no longer receiving medical care at the VAMC.

- A VHA review found a facility failed to inform a veteran that he had not been placed on the liver transplant waiting list due to serious medical complications. Since the medical complications have been resolved, the patient was accepted at VA's national transplant center.

- A VHA review found there was a delay in the nursing service's response to a call for assistance and that a nurse made inappropriate comments to a patient's son. As a result, the chief nurse met with each individual staff member involved in the incident to review staff coverage, communication, and customer service. Management is conducting additional training for diffusing potentially volatile situations. Management is also developing policies and procedures governing lunch coverage, appropriate lines of communication concerning change in patient's condition, and the correct procedure for summoning help.

- A VHA review found a patient improperly received a referral to an outside facility for a magnetic resonance imaging after he was found to be too large for the imaging equipment at the facility. The patient should have been admitted to an observation status bed while a neurologic consult was obtained. As a result, a physician advisor has been made available during off tour admissions to assist the medical officer on duty. Management also stated that a patient will be admitted to a ward or kept in the observation unit when emergency social work services can not be provided during off tours.

- A VHA review found that erroneous entries were made in a veteran's computerized account for medication that he received. A review of the process identified a computer malfunction in VA's computerized patient record system. As a result, the VAMC notified the national online information system and medical staff have been trained to identify these computer malfunctions as they occur.

- A VHA review found an outpatient clinic was delinquent in providing a veteran his x-ray results. The x-ray was taken at a community based outpatient clinic and should have been sent to the VAMC for interpretation, however the x-rays were never received. A second set of x-rays was taken, interpreted, and the results were provided to the veteran. As a result, the facility has implemented a weekly accountability process for diagnostic tests completed off station.

- A VHA review found a veteran's diagnosis and treatment were delayed. The clinicians' failure to perform an examination and follow up on important laboratory test results resulted in a delay in the veteran's diagnosis of colon cancer. As a result, the clinicians involved were counseled on the correct procedures for diagnostic follow up and screening.

- A VHA review found a VAMC failed to provide food and medication to a patient, failed to provide instructions to the patient for a new prescription, and allowed an unauthorized individual access to a patient's room. As a result, the facility instituted corrective actions to preclude future occurrences and the VA police arrested the unauthorized intruder.

- A VHA review found that a veteran was admitted to a VAMC center with an obstructed small intestine and was near death from dehydration because medical personnel had removed fluid from his body, but failed to replace a commensurate amount. Management has initiated review mechanisms to identify potentially adverse patient outcomes.

- A VHA review found that a certified registered nurse anesthetist left a patient in the operating room during surgery in the care of an anesthesia assistant. As a result, the certified registered nurse anesthetist was counseled as to the expected level of care for patients.

- A VHA review found that after being discharged from a VAMC, a wheelchair-bound veteran waited approximately 10 hours before being transported home by a VAMC-contracted ambulance service. As a result, additional transport companies are being considered to prevent future recurrences.

- A VHA review found a VA surgeon inadvertently performed a biopsy of the patient's liver while attempting to perform a kidney biopsy. As a result, the veteran was been advised of his rights under the Federal Tort Claims Act and the benefits claims process under 38 U.S.C. § 1151.

- A VHA review found a VAMC physician failed to properly educate a patient as to the diagnosis and treatment, and the physician was perceived to have been discourteous to the patient as a result of busy schedule. Management instructed the physician to provide ongoing patient education. Additionally, the physician was counseled about being courteous and tactful with veterans, even in stressful situations.

- A VHA review determined that a veteran was denied care at a VA outpatient clinic. Prior to the veteran's application for care, the clinic had reached an established patient limit. As a result of the Hotline inquiry, and acknowledging that the veteran's spinal cord injury makes traveling difficult, the parent VAMC authorized the clinic to accept the veteran for medical care.

- A VHA review found that during the latter part of the workday, a veteran, with a possible broken ankle, was made to walk throughout the VAMC seeking medical attention. The review also found that VA employees were not as attentive to the veteran's needs as they should have been and some lapses in courtesy were acknowledged. As a result, a notice was posted in the orthopedics clinic directing patients to request wheelchair assistance if necessary, and staff were reminded how to handle late-day patients.

- A VHA review found that a patient was not properly dressed and the environment around him was not maintained in a sanitary manner. As a result, a protocol for hourly assessments of patients' level of comfort has been developed and a permanent housekeeper has been assigned to the area.

- A VHA review substantiated allegations of poor medical records documentation on the part of a care provider, and poor patient education and communication regarding changes in psychiatric program structures. The facility has addressed the quality of documentation with the appropriate provider, and implemented a more comprehensive patient education program on the types of psychiatric services provided by the facility.

Employee Misconduct

- As a result of a Hotline inquiry, a VHA review found a VA employee attempted to sell insurance policies to co-workers while on official time. A subsequent investigation also found evidence of unprofessional and improper behavior by the employee during a union meeting. As a result, disciplinary action was taken against the employee, who also received training in ethical and professional conduct standards.

- A VHA board of investigation found that a VAMC police sergeant inappropriately ran a National Crime Information Center computer check to obtain the driving record of a union official. Management is taking administrative action against the officer. Additionally, a policy letter outlining requirements for the use of the computer database has been published, and the VAMC is conducting refresher training for all users of the database.

- A VHA review found that an employee improperly used Government property, resources, and time to make flight arrangements and distribute airline tickets in pursuit of her personal business venture. As a result, the employee was given a written counseling. Additionally, all employees were reminded of the VAMC's policy on organizational ethics.

- A VHA review found that a VA employee stole a co-worker's purse and attempted to cash one of her personal checks. As a result, the VA employee was terminated.

- An investigation by the Deputy Assistant Secretary for Security and Law Enforcement found that VAMC police officers improperly certified firearms qualifications tests and firearms range dimensions. The review found a firearms qualification range did not meet standards established by the VA law enforcement training center. The VAMC police chief and two training officers were given proposed suspensions for falsifying documentation and placed on administrative leave. The police chief retired and all police officers were re-qualified by firearms instructors from a nearby VAMC.

- A VHA review found that an employee reported to work under the influence of drugs, failed to report to duty as scheduled, and failed to follow appropriate leave request procedures. The employee was also observed sleeping at the computer and unsuccessfully drawing a blood sample from a patient. As a result, management proposed removing the employee.

Time and Attendance

- A VHA investigation into allegations of time and attendance abuse found that a VAMC anesthesiology department was being mismanaged. This resulted in confusion among employees about staff schedules and responsibilities, low morale, and a pattern of petty jealousies that led to threats of workplace violence. Following the investigation, the physician manager resigned his position and mandatory training was given to all operating room and anesthesiology staff to address time and attendance, ethical conduct, workplace violence, and sexual harassment.

- A VHA review found time and attendance abuse at a radiology department. The review focused on the employee's time sheets from August 2000 to May 2001 and found that an employee frequently came to work late, as much as an hour, but was charged only for a portion of the tardiness or not charged leave at all. The employee received written counseling and will be charged leave for tardiness and absences not reflected on the employee's time sheets. Additionally, management has scheduled the timekeeper and the employee's supervisors for refresher training on the maintenance of time cards and will closely monitor the employee's tardiness. Management will also take action against the employee's supervisors.

Fiscal Controls

- As a result of a Hotline inquiry, a VHA and employees' union review substantiated an allegation of mismanagement concerning a VAMC employee's enrollment and disenrollment in the union's dental plan through a dental trust company. As a result, union headquarters will work closely with the dental company to ensure enrollments and disenrollments are processed in a timely manner. The employee was reimbursed by the union for erroneous payroll deductions.

- A VHA review found someone used an employee's name and Social Security number to make a $400 payroll deduction purchase at the VAMC canteen. As a result, management has instructed employees of the veterans canteen service to check the identification badge of individuals participating in the voluntary allotment program.

- A VHA review found that VAMC patients were being reimbursed for beneficiary travel expenses to which they are not entitled. The review conceded that patients could be receiving reimbursement for round trip airline tickets and taking less expensive boat transportation for the return trip home. As a result, management implemented a new procedure that will deter any instance of fraud and veterans will be provided with vouchers that can be exchanged for airline tickets.

- A VHA review found a delay of approximately 1 year in the payment of an authorized fee basis provider. A fee basis clerk and the accounting staff attempted to solve the problem without notifying upper level supervisory staff. Once management had been informed, it was determined that VA had neglected to enter an electronic funds enrollment file for the fee-based provider. The provider has since been paid. Management has implemented a procedure to notify appropriate supervisory staff in the event of payment delays.

Patient Safety

- Prompted by a Hotline inquiry, a VHA review substantiated allegations related to environmental safety, inappropriate treatment, and insufficient social services at a VA contracted community residential care home. VAMC management put a temporary hold on placements of veterans at the facility until the areas of concern are remedied and a re-inspection occurs.

- A VHA review found that VAMC medical personnel inappropriately taped a patient's wrists to the arms of his chair and taped his ankles together. As a result, disciplinary action was taken against the employee who committed the abuse and the four employees who witnessed or heard about the incident and failed to intervene or report the abuse.

- A VHA review substantiated an allegation of patient safety violations. During a temporary shutdown of the facility's acute psychiatric unit, a patient was inappropriately placed in the facility domiciliary for care, rather than in a community psychiatric acute care facility. The VAMC transferred the patient to an appropriate community facility for care.

- A VHA review found that patients' meals were improperly being stored in the dialysis unit refrigerator which also contained medications and patient specimens. The review also found that employees were improperly selling Avon products in the dialysis unit. Management implemented a policy whereby patients will be given their meals prior to visiting the dialysis unit and counseled employees on the selling of Avon products in the VAMC.

Privacy Issues

A VHA review found a veteran, who is not currently receiving care at the medical facility, routinely received medication and appointment notices for another veteran who shared his last name and last six digits of his Social Security number. As a result, the chief information officer has adjusted the veteran's identifying information within the computer system to prevent future occurrences.

Government Equipment and Supplies

- Prompted by a Hotline inquiry, a VHA review found that a VA employee misused her official time when she placed numerous telephone calls to non-VA individuals on non-VA issues during the workday. Management took disciplinary action against the employee.

- A VHA review found that an employee was playing "fantasy" sports games with other employees using his Government computer. Another employee was found to have improperly kept irregular duty hours. As a result, management has blocked "fantasy" games from all computers, and a new tour of duty was approved for the employee who kept irregular duty hours.

- A VHA review found that a VA employee misused VA letterhead in order to solicit donations for a private organization. As a result, management counseled the employee.

Contracting Activity

- Prompted by a Hotline inquiry, a VISN review found irregularities in the initial decision-making process and subsequent award of a contract for the construction of an approved $48 million ambulatory care addition at a VAMC. The review substantiated allegations concerning a potential unnecessary award of $800,000 to retrofit the operating room at the ambulatory care addition, and additional cost savings in the initial construction phase had the original contract included isolated power systems in the operating room.

- A VAMC review of contract files found that even though the facility awarded a contract to a local home health care provider, VAMC personnel continued to make referrals to non-contract providers. As a result, the VAMC will ensure patients are being divided equally among contract providers and that non-contract providers are not used.

- A VHA review found a recent renovation failed to include grab bars and automatic opening bathroom doors for easy accessibility for the wheelchair dependent veterans. Management will use station level funds to install the doors, as well as grab bars, which have been on back order since March 2001.

- A VHA review found that a VAMC did not have a clear procedure pertaining to the laundry/linen services provided to non-Government contracted facilities nor did it have procedures in place to control the use of VA-marked linen being exchanged between other medical facilities. As a result, the VAMC is reviewing its contract parameters and services being provided to private facilities and is instituting local policies to define resources for monitoring these services.

Personnel Issues

- A VHA review at a VAMC substantiated the allegation of prohibited personnel practices. A nurse whose professional license was suspended had been placed on a leave without pay status by the VAMC. This employee continued to accept her VA paychecks for a period of 78 days. Additionally, her nursing supervisor continued to authorize the suspended employee's timecards in direct violation of the acting director's instructions. The VAMC has proposed removal of both employees.

- A review conducted by a VAMC determined that a nurse manager failed to follow VA, state, and Federal regulations by ordering a subordinate nurse to take annual leave pending renewal of the nurse's nursing license. To correct the situation, the nurse's annual leave used was reinstated and the nurse was granted administrative leave for those days. Additionally, the VAMC instituted a review of this policy to ensure familiarity and strict compliance with applicable regulations.

Ethical Improprieties

Prompted by a Hotline inquiry, a VHA investigation found three VA employees frequently accepted gifts from a biomedical equipment contractor in the form of food items such as doughnuts, pizza, and sandwiches, valued at $30-50 per occurrence. This matter was forwarded to the General Counsel for appropriate action. In response to this referral, the General Counsel's office provided training on the issue of receipt of refreshments from vendors in nationwide broadcast. General Counsel provided this training pursuant to regulations governing ethics training. In addition, the review determined that neither the biomedical shop nor budget employees were verifying the contractor's invoices. As a result, procedures were revised to require that all invoices be verified by the budget clerk.

Abuse of Authority

Prompted by a Hotline inquiry, a VISN review found that a VA employee improperly received health care services from VA. Although the facility had properly billed the employee (a member of upper management at the medical center) for services totaling $3,810, it was determined this employee was not eligible for this care. As a result, the VISN's chief executive officer issued a reprimand to the chief of staff, who ordered the services, and to the employee who received the services.

Veterans Benefits Administration

Receipt of VA Benefits

- As the result of a Hotline inquiry, a VBA review of a widow's records revealed that she continued to receive DIC benefits during a 4-year period when she was remarried. The VARO created an overpayment of $60,284.

- A VBA review found that a relative of a deceased veteran improperly cashed a compensation check of $20,843. However, the VARO determined this is now a civil issue among heirs and no further VA action was possible.

- A VBA review of a veteran's claims file determined that, although the veteran notified the VA that he had divorced his first wife and remarried, the divorced wife continued to receive an apportionment and to enjoy Civilian Health and Medical Program of the Department of Veterans Affairs privileges. The review found the former spouse's benefits should have been discontinued in January 1988. The VARO notified program managers and proposed a $30,558 overpayment against the former spouse.

- A VBA review found a veteran's benefits were not reduced during incarceration. As a result, the veteran's benefits were reduced to 10 percent causing an overpayment of $3,403.

- A VBA review substantiated the allegation of problems with administrative services. The review found that a veteran was improperly billed for a debt resulting from non-payment of a home loan. As a result, the VARO granted the veteran a pre-foreclosure waiver, relieving him of the outstanding debt of $11,952, and will refund monies already paid against the debt.

Privacy Issues

Prompted by a Hotline inquiry, a VBA investigation found that a violation of the Privacy Act occurred when a veteran's VA certificate of eligibility for a home loan and the DoD Certificate of Release or Discharge from Active Duty were erroneously given to another veteran. The employee involved in the incident was counseled and provided refresher training. The entire staff is now receiving periodic training to reinforce the importance of preventing a recurrence. Additionally, a system of checks and balances has been integrated to minimize the likelihood of a resulting grant of fraudulent benefits.

Office of Information and Technology

As the result of a Hotline inquiry, a VA Central Office review found the receipt of inappropriate and unsolicited Internet electronic mail by a VA employee. Consideration will be given to adding general guidance to VA employees on how to mitigate this problem within the existing framework of VA Directive 6103, "VA Electronic Mail System."

Outside Organization

Prompted by a Hotline inquiry, an Office of General Counsel review substantiated the unauthorized use of the Department of Veterans Affairs' seal in a mortgage company's literature. The Office of General Counsel contacted the company and they agreed to remove the seal from future correspondence.

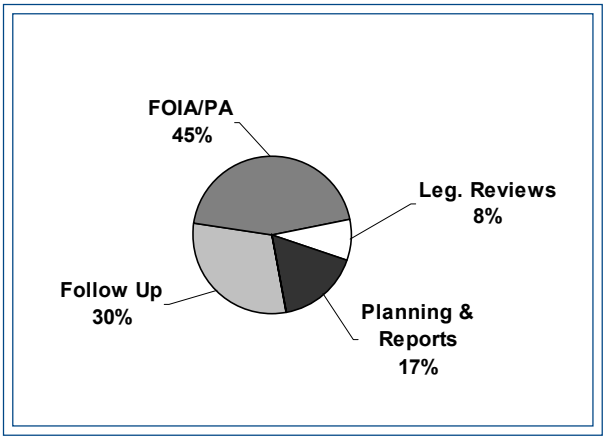
II. OPERATIONAL SUPPORT DIVISION

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 nine 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 $4.1 billion of actual or potential monetary benefits as of September 30, 2001. Of this amount $2.6 billion is resolved, but not yet realized as VA officials have agreed to implement the recommendations, but have not yet done so. The remaining $1.5 billion primarily relates to one audit report; the Under Secretary for Health has deferred concurring or non-concurring with the recommendation to include priority group 7 veterans in the Veterans Equitable Resource Allocation system until other options are considered.

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, 2001, VA had 64 open internal OIG reports with 207 unimplemented recommendations. After obtaining information that showed management officials had fully implemented corrective actions, the Division took action to close 70 reports and 376 recommendations with a monetary benefit of $451 million.

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, Department of Justice, and 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 176 requests under the Freedom of Information and Privacy Acts and released 232 audit, investigative, and other OIG reports. Information was totally denied in 8 requests and partially withheld in 100 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 a written response within 20 work days, as required. There are no cases pending over 6 months.

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 63 legislative, 55 regulatory, and 37 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 request a status update.

VA Office	Unimplemented OIG Reports and Recommendations			
	Total		FY 1998 and Earlier (note)	
	Repts	Recoms	Repts	Recoms
VHA	37	132	3	4
VBA	8	44	1	1
A&MM	16	28	0	0
GC	1	1	0	0
HRA	1	1	0	0
I&T	1	1	0	0
Total	**64**	**207**	**4**	**5**

Office of Acquisition & Materiel Mgmt (A&MM)
Office of General Counsel (GC)
Office of Human Resources and Administration (HRA)
Office of Information and Technology (I&T)

The chart above lists the total number of unimplemented OIG reports and recommendations. It also provides the total number of unimplemented reports and recommendations issued in FY 1998 and earlier.

There are two additional 1998 reports not listed in the above "FY 1998 and earlier" columns and not listed in the below summaries because they are contractor related reports. One is an A&MM acquisition center report and one is a VHA facilities management report. Both reports are listed in Appendix B on contractor reviews.

We are particularly concerned about the FY 1998 and earlier reports that have not been implemented 3 years after being issued. The status and OIG concerns on these FY 1998 and earlier reports are summarized as follows.

Veterans Health Administration

Unimplemented Recommendations and Status (FY 1998 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: In July 2001, the U.S. General Accounting Office issued a report (GAO-01-768, VA LONG-TERM CARE, Oversight of Community Nursing Homes Needs Strengthening) that had similar recommendations as this 1994 VA OIG report. In September 2001, VHA put into their concurrence process a draft directive on community nursing home evaluation and follow up services that would address both reports. No planned completion date has been provided.
Concern: The OIG is concerned because in the past 7 years we have received numerous prior draft directives, however none has been finalized. 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: In August 2001, VHA stated the major obstacle to the implementation of this recommendation has been the inability of VA's computer systems to develop a method for sharing the necessary information in a manner that is timely, ensures accuracy of data, and protects the confidentiality of patient records. A plan to support system-wide computerized advisories was presented to the VA information technology advisory council in August 2001, however it was given a low priority. VHA intends to again contact the council, pursue a model developed by VISN 20, and focus on VISN and facility based alerts. No planned completion date has been provided.
Concern: The OIG report included recommendations that were meant to strengthen areas that may reduce the 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 because the latest VHA status shows that after 5 years there still is not a plan developed to implement the recommendation.

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 draft directive to the OIG in January 2001 and the backup data to support the directive in May 2001. However, the OIG has determined this backup data was unacceptable. No planned completion date is available from the program office.
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. As a result, over $7.2 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 1998 and Earlier Reports)

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: VBA received correspondence from the Defense Manpower Data Center informing them that the Defense Finance Accounting Service - Denver discovered an error in their reporting of drill information to the Center, affecting U.S. Army, Navy, and Air Force pay data. The Service subsequently made corrections to these programs and sent a corrected April 2001 extract to the Center. However, the Service is unable to provide corrected submissions for reserve drill data prior to April 2001. VBA is currently examining ways to obtain prior year data so they can implement this recommendation. No planned completion date has been provided.
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

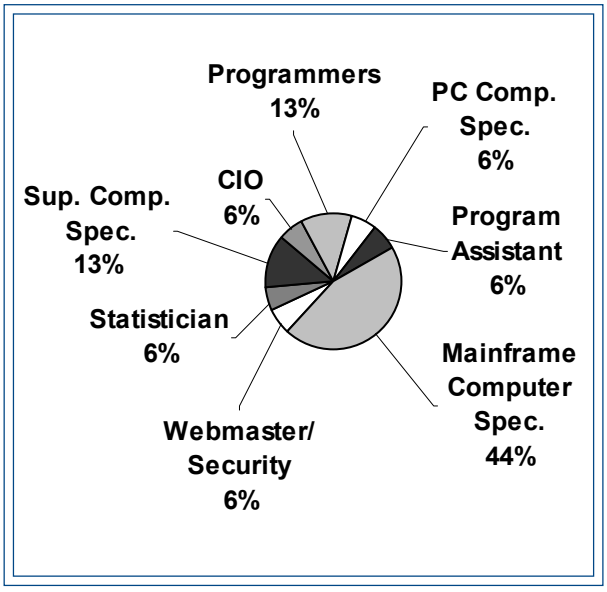
Mission Statement

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, 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 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 17 FTE currently allocated in Washington, Austin, Chicago, and Atlanta. These FTE are devoted to the following areas:



Overall Performance

Master Case Index (MCI)

During this reporting period, we provided our field personnel with more than 80 enhancements of the MCI, the OIG's enterprise database. We refined features offered on our new Hotline form that tracks all phone calls received by that Division. We also successfully installed *Oracle 8i* database on our test server and "web-enabled" several MCI forms and reports. When testing and conversion are complete, we will no longer be in a client-server environment. Consequently, our users will be able to take advantage of enhancements immediately instead of waiting for periodic updates distributed on compact disks.

Internet and Electronic Freedom of Information Act

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 570,000 times by more than 123,000 visitors. Our most popular reports were downloaded over 52,000 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 40,000 downloads.

We posted an electronically-redacted administrative investigation report in our electronic reading room in compliance with the Electronic Freedom of Information Act. Additionally, we published 22 other reports, over 50 Office of Investigations press releases, and other OIG publications, including this semiannual report to Congress, on our website.

Information Management, Security, and Departmental Coordination

We continually increase security of sensitive OIG data and systems through OIG employee information security education and awareness, timely computer security incident response, and additional internal network monitoring. We provided focused security training during the last new OIG employee training session and during the OIG Office of Management and Administration offsite conference. Our proactive internal reviews have helped us avoid most of the virus outbreaks within the VA. We are working with the various VA system administrators to improve identification of OIG accounts that should be closed or disabled.

We actively participate in the development of Departmental policies and programs to improve VA information security, IT accessibility, and Internet resources and utilization. We presented a training session on the impact of the computer crime statutes on VA information security officers at the Department's 2001 Information Security conference. We addressed the legal elements required in computer logon banners and user agreements that affect an information security officer's and a system administrator's ability to monitor their networks and computer systems, especially when unauthorized use is suspected.

We worked directly with VBA to help ensure that their logon banners and user agreements meet the legal elements of the computer crime statutes. This effort should remove any legal impediments to the OIG reviewing, investigating, and prosecuting computer crimes within VBA. We are undertaking a similar effort with VHA and later with the VA Office of Cyber Security in the form of VA-wide policy and guidance. Our proposed warning banners guidance was incorporated into the VA's Internet/intranet policy.

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.

During this reporting period, the OIG statistician provided statistical consultation and support on eight sampling plans for proposed audit projects and OHI proactive program evaluations. Additionally, the OIG statistician and a computer specialist provided statistical support for all CAP reviews. This support involved preparing and

processing the random samples of full-time VAMC employees who were part of the employee satisfaction survey. They also provided data concerning purchase card use at each facility. Finally, these individuals provided support to process the CAP data collected while on-site.

Information Technology Training Initiative

We have 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, 103 employees have received 268 days of instructor-led training in Washington, DC, while 64 field employees have received 82 days of training locally. A recent survey of attendees confirmed an expected level of improved competency in the use of the *Microsoft Office* suite of applications.

DATA ANALYSIS SECTION

The Data Analysis Section (DAS) analyzes data in VA computer files and systems. They develop proactive computer profiles that search VA computer data for patterns of inconsistent or irregular records with a high potential for fraud and they refer these leads to OIG auditors and investigators for further review.

They conduct reviews that identify invalid or erroneous information in VA computer files that can lead to bad results or erroneous conclusions. 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. They also provide ADP technical support to preaward and postaward OIG audit reviews that assist VA contracting officers in price negotiations and to ensure reasonableness of contract prices.

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

Data Mining - Collaborations with VA Office of Financial Policy, Financial and Systems Quality Assurance Service

During this reporting period, the DAS staff worked closely with auditors from the Service to test fraud detection computer profiles. The DAS staff provided the results of five computer profiles to determine if any fraud was evident.

- Quality Assurance Service auditors reviewed 507 claim folders of veterans meeting the criteria contained in these profiles at 6 VAROs and referred 42 cases as potential fraud to OIG investigators. Of the 42 cases referred, 20 were identified as having potential monetary recoveries totaling more than $1.8 million.

Collaborations with VBA

The DAS staff worked with VBA to form a collaborative effort to help identify internal and external fraud within VBA computerized systems. The effort is currently limited to computer profiles developed for the compensation and pension area, but long-range plans include developing additional profiles that include the VA life insurance and loan guaranty programs. Examples of this collaboration include:

- DAS staff provided VBA with the results of one-time payment reviews and a list of beneficiaries with no Social Security number or date of birth on the VBA computer record. VBA reviewed the results at five VAROs. No cases of potential fraud were referred to OIG investigators. As a result of their reviews, VBA is considering a mailing to beneficiaries to obtain a valid Social Security number and date of birth to repair each record. Such records are highly susceptible to internal

fraud because they cannot be easily tracked by VBA (no Social Security number) or determined to be likely deceased by matching to other Federal and local databases (no date of birth). Obtaining this vital information directly from veterans and their spouses will do much to prevent their use in employee fraud in the future.

- DAS staff raised the issue of the fraud vulnerability of returned benefit checks with VBA officials in joint meetings during this reporting period. DAS staff discovered several instances in which a veteran had died and his monthly benefit check was returned only to have the check re-issued with the new month's totals added to the sum. As a result of the DAS team's referral to VBA, the VBA Philadelphia Insurance Staff was tasked to complete a study of returned mail in cooperation with the Compensation and Pension Service. The report, when issued, will identify the best methods for locating missing veterans who have direct deposit bank accounts. Applying internal controls to this procedure will help protect VBA from employee fraud.

- DAS staff met with VBA representatives on several occasions to discuss data mining and how VBA could utilize it to detect fraud in their computer systems. DAS provided copies of certain VBA files to the Data Management Office for testing. At their request, DAS visited the Philadelphia Insurance Center to discuss methods they could use to detect internal fraud in VA's insurance systems.

- VBA Compensation and Pension Service representatives visited the DAS staff following the Secretary's announcement of the VARO Atlanta employee fraud case. Their purpose was to support the DAS staff's efforts to detect fraud in the Atlanta case and assist the OIG national fraud review at all VAROs. VBA staff exchanged ideas with DAS staff, made suggestions to enforce the criteria used to detect fraud, and interpreted some of the VBA policies, processes, and program functions that are vital to data mining efforts.

Postaward and Preaward Contract Reviews

DAS staff assisted OIG auditors by providing automated data processing support in obtaining and analyzing the sales data provided by independent vendors seeking or under contract with the VA. During the course of providing this assistance, DAS staff coordinated with company IT personnel and management, attorneys, and OIG auditors to ensure the needs of the audit were met and that prices the VA pays for items were equitable and in accord with the terms of the contract. Examples of this support include:

- DAS received 18 compact disks containing 194 files of sales information from a corporation under preaward and postaward contract review. The sales were from five different companies under the corporate umbrella and the data covered nine different contracts with VA. DAS staff worked with corporate attorneys and company IT staffs and identified a common preferred customer (i.e., those customers purchasing large quantities of whatever product or service is being sold). Sales made by companies to preferred customers and the unit prices these companies are charged are the basis VA contracting officers use to determine what price the VA should be charged on like items purchased from the same corporation. As a result of the DAS staff's efforts, OIG auditors will be able to determine the amount of overpayment the VA has been charged and recover the funds.

- A company under postaward review provided DAS staff members with 64 computer tapes containing 34 million sales transactions the company made to all of their customers during the last 9-year period. There were several problems with the data. The company computer records do not specifically identify sales made to the Federal Government and company sales made to the VA do not agree with the company's Government sales reports. DAS staff worked with company representatives and IT staff to determine a method for identifying sales to VA. The work was difficult

because no easy identifier exists in the individual sales transactions. The solution therefore had to rely on data other than that when viewed independently and collectively resulted in a fair determination that the customer for the sale was indeed the VA. As a result of their efforts, the figures VA audit staff arrived at and the figures the company reported in their sales reports are closer to agreement.

Special Projects - Fraud

Fraud and other illegal activities committed against VA's programs can amount to millions of dollars. Contracts, procurements, and veterans benefits programs are inherently vulnerable to fraud due to the large expenditures of funds associated with purchasing the items necessary for an agency as large and diverse as VA and for compensating millions of veterans for their service to their country. The DAS staff took an aggressive approach to finding and reporting fraud by developing computer profiles that reflect the results of actions taken by fraudulent employees to defraud VA. By mimicking the fraudulent actions and searching VA files for similar action patterns, the DAS staff continues to provide OIG investigators and auditors with leads to potential fraud. Among them, the computerized death match and the bogus veteran profile have produced numerous convictions and millions of dollars in recovered monies. Similar efforts currently in progress include:

- DAS staff provided OIG investigators with data that indicated there could be fraudulent activity within the area serviced by a VARO. Several patterns in the VARO data indicated abnormalities in empirical data such as life expectancy, etc. DAS staff coordinated with analysts from the U.S. Secret Service and VBA Philadelphia Insurance Center in an effort to notify and interview payees associated with altered checks. DAS staff also coordinated with VBA and the VARO to identify and interview payees relating to internal issues of concern by the VARO. Letters have been mailed to recipients of VA benefits in the VARO area asking them to verify the payee's existence and their entitlement to the VA benefits they are receiving. DAS staff created an electronic interview process to assist OIG investigators with this benefits review.

- When fraud was first suspected at a VARO, DAS staff quickly discovered approximately $6 million in suspected fraud and three primary suspects, who were indicted shortly thereafter. Subsequently, DAS staff was able to identify an additional 10 co-conspirators and approximately $5 million in suspicious benefits payments associated with this case.

OIG National Review for Fraud

To support the national review of VBA offices to detect potential fraud, the DAS staff developed seven computer profiles in order to detect similar patterns of fraud discovered in VAROs during the last 3 years. The profiles were run against nationwide data for as many as 5 years and the information was provided to audit teams visiting each VARO. DAS staff continue to support auditors uncovering new fraud cases that need to be researched.

Other Workload

During this reporting period, DAS staff completed 187 ad hoc requests for information and data submitted from all OIG operational elements. They supported 12 OIG CAP reviews for VAMCs and 6 CAP reviews for VAROs. They provided 67 proactive reports using data mining to detect potential fraud in VA systems and programs and they completed 72 requests for auditors performing VA postaward and preaward contract reviews of private vendors under contract with the VA.

IV. RESOURCES MANAGEMENT DIVISION

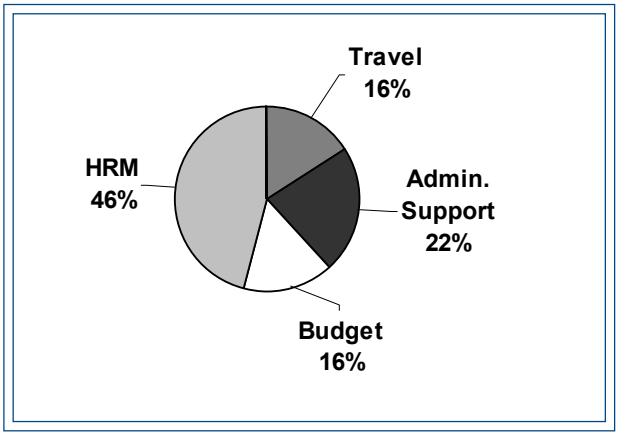
Mission Statement

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 which are allocated as follows:



Overall Performance

Budget

The staff executed 99.95 percent of the OIG's FY 2001 budget authority.

Human Resources Management

During this period, the staff brought 27 new employees on board. In addition, the staff processed 86 personnel actions and 258 awards.

Travel

By the nature of our work, OIG personnel travel almost continuously. As a result, we processed 1,927 travel and 44 permanent change of station vouchers.

Administrative Support

The administrative staff performed numerous administrative functions, office renovation plans, telephone installations, and the procurement actions.

OTHER SIGNIFICANT OIG ACTIVITIES

President's Council on Integrity and Efficiency

- OIG Financial Audit Division staff participate in the audit executive committee financial statements audit workgroup. The workgroup facilitates communication of financial statement audit issues throughout the Federal community.

- OIG Audit Planning staff participate in the Government Performance and Results Act (GPRA) coordinator's interest group, a sub-group of the audit committee. The GPRA interest group was formed in 1997 to help address how to best implement the GPRA internally and how to integrate the requirements of the GPRA into the audit, inspection, and investigation functions of the OIG.

OIG Management Presentations

9th Annual Leadership VA Alumni Association Forum

The Inspector General participated in a panel discussion of VA leaders at this forum, responding to questions from the VA executives and managers attending.

VBA Leadership Conference

The Inspector General made a presentation on internal controls and recent cases of employee fraud.

VA Claims Processing Task Force

The Assistant Inspector General for Auditing served as a member of the Secretary's task force. The task force assessed and critiqued VBA's organization, management, and process in order to develop recommendations to greatly improve VA's ability to process veterans' claims for disability compensation and pension.

VA Procurement Reform Task Force

The Deputy Assistant Inspector General for Auditing served as a member of the Secretary's task force. The task force is charged with reviewing all facets of VA's acquisition system and to make specific recommendations to enhance the effectiveness of VA procurement, contracting, and materials management practices. The task force is expected to issue a report on its findings in Fall 2001.

VHA's Compliance Days Conference

The Deputy Assistant Inspector General for Healthcare Inspections served as a panel member in discussions at the conference held in Minneapolis, MN. Senior VHA leaders, conference officers from all VA facilities in the nation, and interested financial and billing managers attended the 3-day conference on billing compliance issues.

Secretary's Preparedness Review Working Group

The Deputy Assistant Inspector General for Management and Administration represented the OIG on the working group which was charged to conduct a comprehensive review of VA's preparedness to respond to different types of terrorist attacks anywhere in the United States. The working group briefed the Secretary on its recommendations and provided a final report.

VA Health Care Contracting Training

OIG audit managers from the Contract Review and Evaluation Division provided a presentation on

contracting for scarce medical specialists' services to VHA contracting officers in Little Rock, AR. The presentation covered the history of contracting with affiliates for scarce medical resources, the preaward review process, and common problems the OIG has encountered over the last year performing these reviews. The presentation will be used to develop an on-line course for contracting officers.

Presentation to VA Procurement Reform Task Group

OIG representatives from the Contract Review and Evaluation Division made a presentation to task group members. The presentation covered OIG reviews of Federal Supply Schedule contracts and our observations concerning commercial acquisition and marketing practices.

Office of Acquisition and Materiel Management Seminar

In April, the Financial Audit Division Director provided a presentation on nonexpendable equipment and excess property accounting and controls at an Office of Acquisition and Materiel Management seminar.

VA Information Security 2001 Conference

The OIG information security officer presented a training session on the impact of the computer crime statutes on computer logon banners, user agreements, and system monitoring/oversight. Also the Central Office Audit Operations Division Director and security audit project managers made a presentation on our vulnerability assessments and penetration testing at the conference in Orlando, FL. The conference was attended by over 500 VA information technology and security staff.

Presentation at the VA Information Technology Conference

The Central Office Audit Operations Division Director and security audit project managers teamed with the VISN 22 information security officer on a presentation on the posture of information security in VA at the Information Technology Conference in Austin, TX. The conference offered information and training on the latest IT to over 3,000 attendees.

Awards

Secretary's Award

Secretary of Veterans Affairs, Anthony J. Principi, presented the *Secretary's Award* to the OIG Northeast field office for their efforts following the terrorist attack. The award, presented personally by the Secretary to Bruce T. Sackman, Special Agent in Charge of the Northeast field office, recognized "…The compassionate assistance rendered…to veterans and indeed all who needed aid…" and that their assistance "…was of incalculable value and reflects great credit on yourselves and your team, the Department and the United States Government."

Secretary (r) presents award

Greater Boston Federal Executive Board's 2001 Excellence in Government Awards

The Board established the Excellence in Government Awards in 1974 as a means of celebrating local Federal employee successes. Held each year during Public Service Recognition Week, this prestigious event recognizes and rewards the "best and the brightest" in Federal service. Nominees represent outstanding Federal employees who have distinguished themselves with exceptional performance, integrity, and dedication to public service among the thousands of Federal employees in the Greater Boston community. The program consists of 14 distinguished categories that are designed to encompass a broad spectrum of achievement among Federal employees. A blue ribbon panel comprised of local leaders in business, academia, and community efforts reviewed each nomination and came to a consensus to determine this year's winners:

- Special Agent Steven J. Plante, VA OIG Boston resident agency, won the Professional Employee of the Year as a result of his successful efforts on the prosecution of a VA nurse on a multiple homicide and bomb threat case, now known as the Kristen Gilbert investigation.

- Special Agent in Charge Bruce T. Sackman, VA OIG Northeast field office, was a finalist for the Distinguished Federal Manager award for his numerous achievements in the fields of investigation and management.

Commendation from the Deputy U.S. Attorney, District of South Dakota

The OIG often works closely with other law enforcement organizations in task forces designed to identify and ensure prosecution of individuals whose crimes cross agency boundaries. On occasion, in addition to investigative participation, the OIG provides these task forces with audit assistance to help analyze and evaluate documentary evidence. In one such task force, which led to the prosecution of over 20 individuals, some of which were defrauding VBA, the OIG received a complementary letter from the prosecutor in the case for our assistance to the task force.

"…we would express our sincere appreciation for the support provided to the Pine Ridge Task Force by your agents and auditors. As you are aware, this significant law enforcement effort has resulted in numerous indictments of individuals at all levels of tribal government. … As the audit participation in this endeavor draws near it's completion, we would like to commend Dennis Capps, Jim Pruitt, and Robin Frazier of your Kansas City Audit staff,… and Patty Weyburn and Kevin Gibbons of your Chicago Audit staff …"

Deputy U.S. Attorney
District of South Dakota

OIG Congressional Testimony

- In April 2001, the Inspector General testified before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs. The testimony provided OIG's assessment of the VA Automated Information System security program.

- In July 2001, the Inspector General testified before the Senate Committee on Veterans' Affairs. The testimony addressed VHA restrictions on filling privately written prescriptions that was address in the OIG audit report, Audit of VHA Primacy Co-Payment Levels and Restrictions on Filling Privately Written Prescriptions for Priority Group 7 Veterans, issued in December 2000.

- In September 2001, the Inspector General testified before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs. The testimony addressed the OIG work concerning the VA Medical Care Collection Fund and indicated the OIG has reviewed selected fund issues during the past several years and has identified opportunities to enhance recoveries.

- In September 2001, the Inspector General and Assistant Inspector General for Healthcare Inspections testified before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, at field hearings held in Indianapolis, IN. The testimony covered patient care issues at VAMC Indianapolis and the Northern Indiana Healthcare System (Marion and Ft. Wayne).

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 Public Law 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 30 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				
00-02860-67 4/11/01	Combined Assessment Program Review, VA Medical Center, Manchester, NH	$9,486	$9,486	
00-00709-88 5/31/01	Combined Assessment Program Review, Richard L. Roudebush VA Medical Center Indianapolis, IN			
00-01229-102 6/13/01	Combined Assessment Program Review, VA Central Iowa Health Care System Des Moines and Knoxville, Iowa			
01-00272-84 6/25/01	Combined Assessment Program Review VA Regional Office Phoenix, Arizona	$76,800	$76,800	
01-00507-79 6/27/01	Combined Assessment Program Review, Ralph H. Johnson VA Medical Center Charleston, SC	$130,000	$130,000	
00-02811-89 6/29/01	Combined Assessment Program Review of the South Texas Veterans Health Care System	$63,241	$63,241	
01-01074-101 6/29/01	Combined Assessment Program Review of the Southern Arizona VA Health Care System			
01-00413-85 7/2/01	Combined Assessment Program Review of the VA Northern California Health Care System	$231,000	$231,000	
01-00079-104 7/2/01	Combined Assessment Program Review of the Oklahoma City Veterans Affairs Medical Center			
00-02066-51 7/10/01	Combined Assessment Program Review of Harry S Truman Memorial Veterans' Hospital Columbia, MO			
01-00685-120 7/24/01	Combined Assessment Program Review VA New Jersey Health Care System	$70,000	$70,000	
00-02096-125 7/24/01	Combined Assessment Program Review, Royal C. Johnson Memorial VA Medical and Regional Office Center Sioux Falls, SD	$423,424	$423,424	

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)				
01-00788-108 8/8/01	Combined Assessment Program Review, VA Tennessee Valley Healthcare System	$103,000	$103,000	
00-02681-121 8/13/01	Combined Assessment Program Review of the New Mexico VA Health Care System	$321,230	$321,230	
00-02010-113 8/15/01	Combined Assessment Program Review, VA Medical Center Cincinnati, OH	$225,321	$225,321	
00-01199-129 8/15/01	Report of Follow-up to the Combined Assessment Program Review of the VA Northern Indiana Health Care System, Fort Wayne and Marion, Indiana			
INTERNAL AUDITS				
99-00192-65 4/4/01	Audit of VA Medical Center Management of Engineering Supply Inventories	$168,400,000	$168,400,000	
99-00057-55 8/13/01	Audit of the Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network (VISN) 8	$1,480,000,000	$0*	
OTHER OFFICE OF AUDIT REVIEWS				
01-00750-56 4/30/01	Attestation of the Department of Veterans Affairs "Detailed Accounting Submission" for Fiscal Year 2001			
01-01855-75 5/15/01	Evaluation of the Department of Veterans Affairs Purchasing Practices			
01-00759-69 5/18/01	Review of Treatment of Non-Veterans at Veterans Affairs Medical Center San Juan, PR	$137,214	$137,214	
00-02797-78 5/21/01	Management Letter: Review of Department of Veterans Affairs Activities to Collect, Review, and Use Information that Identifies Individuals Who Access the Department's Internet Sites			
00-01141-83 6/13/01	Advisory - Management of High Risk Disbursements			

* VHA deferred on concurrence or non-concurrence with the recommendation to include priority group 7 veterans in the Veterans Equitable Resource Allocation system until other options are considered.

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)				
00-01702-91 6/26/01	Management Letter - Audit of Department of Veterans Affairs Consolidated Financial Statements (CFS) for the Year Ended September 30, 2000			
00-01702-96 6/26/01	Management Letter - Audit of VA's Fiscal Year 2000 Consolidated Financial Statements, General Computer Controls Review at VA Medical Center Bay Pines, FL			
00-01702-97 6/26/01	Management Letter - Audit of VA's Fiscal Year 2000 Consolidated Financial Statements, General Computer Controls Review at the Austin Automation Center			
00-01702-98 6/26/01	Management Letter - Audit of VA's Fiscal Year 2000 Consolidated Financial Statements, General Computer Controls Review at the Philadelphia Benefits Delivery Center			
00-01702-99 6/26/01	Management Letter - Audit of VA's Fiscal Year 2000 Consolidated Financial Statements, General Computer Controls Review at the Hines Benefits Delivery Center			
00-01702-100 6/26/01	Management Letter - Audit of VA's Fiscal Year 2000 Consolidated Financial Statements, General Computer Controls Review at the VA Medical Center Martinsburg, WV			
00-02773-106 7/13/01	Memorandum Report, Evaluation of the VA Enhanced-Use Lease Program			
00-02165-119 8/1/01	Evaluation of the Department of Veterans Affairs Health Eligibility Center Centralized Means Test Pilot Program			
00-02772-105 8/30/01	Memorandum Report, Evaluation of Enhanced Health Care Resources Sharing Authority			
99-00175-134 9/4/01	Review of Allegations of Mismanagement Relating to Closure, Consolidation, and Contracting for Certain Specialized Medical Services in Veterans Integrated Service Network 12			
00-01199-135 9/4/01	Review of Allegations Involving Operations of the VA Community-Based Outpatient Clinic South Bend, IN			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT REVIEWS *				
01-01052-68 4/11/01	Review of Federal Ceiling Price Overcharges Under Federal Supply Schedule Contract Number V797P-5439x Awarded to Baxter Healthcare Corporation, Deerfield, IL			$2,017
01-01196-70 4/11/01	Review of Proposal Submitted by University of Minnesota Physicians for Chief, Department of Radiology, at VA Medical Center Minneapolis, MN	$101,989		
99-00093-72 5/2/01	Nycomed Amersham's Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Numbers V797P-5982n and V797P-5317x			
00-02452-73 5/2/01	Review of Purdue Frederick Company's and Purdue Pharma L.P.'s Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Numbers V797P-5259X and V797P-5965N			$6,944
01-01023-74 5/2/01	Review of Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5354x, Awarded to Novartis Pharmaceuticals Corporation, East Hanover, NJ			$921
00-02763-86 6/5/01	Review of Federal Supply Schedule Proposal Submitted by Fisher Healthcare Under Solicitation Number M5-Q52B-99	$4,905,550		
98-00093-87 6/5/01	Postaward Review of Federal Supply Schedule Contract Number V797P-3523j Awarded to Western Medical, LTD, Tenefly, NJ			$105,288
01-01130-93 6/20/01	Review of Proposal Submitted by Department of Radiology, University of Arkansas for Medical Sciences Under Solicitation Number RFP V598P-1092 for Nuclear Medicine Services at the Central Arkansas Veterans Healthcare System Little Rock, AR	$335,160		
01-00706-95 6/21/01	Review of Proposal Submitted by Department of Radiology University of Arkansas for Medical Sciences Under Solicitation Number RFP V598P-1093 for Radiologic Professional Services at the Central Arkansas Healthcare System Little Rock, AR	$760,347		

* 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 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)				
01-00751-107 7/10/01	Review of Proposal Submitted by Acuson Corporation, Under Solicitation Number M6-Q9-00, for Ultrasound Imaging Systems	$588,500		
01-01759-114 7/31/01	Audit of Termination for Convenience Settlement Proposal Submitted by Booz Allen & Hamilton, Inc., Under Contract Number V101(93)P-1445, Task Order 39	$12,140		
01-01343-122 8/1/01	Post-Award Review of Electric Mobility Corporation's Federal Supply Schedule Contract Number V797P-3158k			
01-02096-123 8/1/01	Review of Organon Inc.'s Voluntary Disclosure of Pricing Violations Under Federal Supply Schedule Contract Number V797P-5381x			$17,731
00-01933-124 8/1/01	Review of Zenith Goldline Pharmaceutical Inc.'s Voluntary Disclosure of Price Reductions Under Federal Supply Schedule Contract Number V797P-5305x			$347,968
00-02782-130 8/20/01	Review of Ethicon Inc.'s Analysis of Contract Compliance for Federal Supply Schedule Contract Numbers V797P-5663m and V797P-5385x			
01-02074-132 8/23/01	Review of Proposal Submitted by University of Miami, Department of Anesthesiology, Under Solicitation Number RFP 546-44-01, for Anesthesiology Services at the Department of Veterans Affairs Medical Center Miami, FL	$395,040		
00-00396-133 9/4/01	Review of Bracco Diagnostics, Inc.'s Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585, Under Federal Supply Schedule Contract Number V797P-5261X			$16,021
01-01584-136 9/14/01	Review of Proposal Submitted by Spacelabs Medical, Under Solicitation Number RFP-797-FSS-99-0025, for Medical Equipment and Supplies	$336,520		
00-01130-142 9/24/01	Settlement Agreement, Review of Johnson & Johnson Medical, Inc.'s Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract V797P-5731M			$3,783,000
00-02783-143 9/26/01	Review of Ernst & Young LLP's Analysis of Depuy Orthopaedic Technology's Federal Supply Schedule Contract V797P-3416j			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
ADMINISTRATIVE INVESTIGATIONS				
01-00365-71 5/4/01	Administrative Investigation, Research Foundation and Employee Award Issues, VA Medical Center Kansas City, MO			
00-01900-77 5/22/01	Administrative Investigation, Misuse of Position and Other Issues, Jerry L. Pettis Memorial Veterans Medical Center Loma Linda, CA			$500
01-00865-90 6/18/01	Administrative Investigation, Misconduct and Resource Misuse Issues, Ralph H. Johnson VA Medical Center Charleston, SC			$647
99-01434-103 7/12/01	Administrative Investigation, Misuse of Frequent Flyer Miles and Other Travel Issues, Veterans Integrated Service Network 7 Atlanta, GA			$1,271
01-01062-115 7/18/01	Administrative Investigation, Misuse of Government Resources and Other Issues, VHA Office of Information Washington, DC			
00-01632-117 7/20/01	Administrative Investigation, Irregularities in Employee Relocation Reimbursements and the Workers' Compensation Program, VA Medical Center West Palm Beach, FL			
01-02075-116 7/24/01	Administrative Investigation, Burial of Indigent Veterans Issue, VA Regional Office, VBA Chicago, IL			
01-01893-127 8/7/01	Administrative Investigation, Employee Drug Testing Program Issue, VA Central Office Washington, DC			
01-01008-131 8/27/01	Administrative Investigation, Acceptance of Compensation and Gift Issues, VA Southern Nevada Healthcare System Las Vegas, NV			
HEALTHCARE INSPECTIONS				
00-01535-43 4/2/01	Patient Care Management at VA Gulf Coast Veterans Health Care System Biloxi/Gulfport, MS			
00-00525-30 4/3/01	Patient Care Issues at the VA Greater Los Angeles Health Care System			
00-01293-42 4/26/01	End-of-Life Care Issue, VA Palo Alto California Healthcare System Palo Alto, CA			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
HEALTHCARE INSPECTIONS (Cont'd)				
00-00358-58 5/14/01	Combined Assessment Program Review Follow-Up, Carl Vinson VA Medical Center Dublin, GA			
00-00986-80 5/21/01	Healthcare Inspection, Patient Care and Management Issues at the West Texas VA Health Care System Big Spring, TX			
01-00787-81 6/1/01	Allegation of Wrongful Death in a VA Community Contract Nursing Home			
00-02885-92 6/21/01	Healthcare Inspection, Alleged Medical Treatment Issues at the Department of Veterans Affairs Palo Alto Health Care System Palo Alto, CA			
00-02629-94 7/3/01	Healthcare Inspection, Quality of Care Provided to a Patient, VA Gulf Coast Veterans Health Care System Biloxi, MS			
00-01383-82 7/16/01	Healthcare Inspection, Alleged Denial of Medical Care to Patients, Edward Hines Jr. VA Hospital Hines, IL			
00-02987-109 7/16/01	Quality of Care Provided to Patients in the Extended Care Unit, Department of Veterans Affairs Medical Center Dayton, OH			
01-00519-118 7/26/01	Healthcare Inspection, Alleged Research Improprieties and Quality of Care Issues, Department of Veterans Affairs Medical Center Miami, FL			
01-00119-110 7/30/01	Healthcare Inspection, Alleged Patient Abuse, Veterans Affairs Medical Center Danville, IL			
01-01091-126 8/7/01	Healthcare Inspection, Alleged Patient Abuse Due to the Closure of the Operating Room, Edward Hines, Jr. Veterans Hospital Hines, IL			
00-02759-128 8/14/01	Healthcare Inspection, Treatment of Patients in Nursing Home Care Units at the Department of Veterans Affairs Medical Center Philadelphia, PA			
01-00223-111 8/30/01	Healthcare Inspection, Gender Identity Disorder Services for Patients at the James H. Quillen Veterans Affairs Medical Center Mountain Home, TN			
TOTAL:	**78 Reports**	**$1,657,625,962**	**$170,190,716**	**$4,282,308**

APPENDIX B

CONTRACT REVIEW REPORTS FOR WHICH A CONTRACTING OFFICER DECISION HAS 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
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 before the VA Board of Contract Appeals; no planned resolution date available.
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, 00-01584-73, 5/31/00		$297,833	Pending receipt of contracting officer price negotiation memorandum (PNM); no planned resolution date available.
Review of Federal Supply Schedule Proposal Submitted by Olympus America Inc., Under Solicitation Number RFP 797-652A-99-0001, 00-00239-32, 1/18/01		$2,986,205	Pending receipt of contracting officer PNM; anticipated award date is November 1, 2001.
Review of Federal Supply Schedule Proposal Submitted by Omnicell, Inc., Under Solicitation Number RFP-797-FSS-99-0025, 01-00460-39, 1/31/01			Pending receipt of contracting officer PNM; anticipated award date is November 1, 2001.
Review of Federal Supply Schedule Proposal Submitted by Roche Diagnostics Corporation Under Solicitation Number RFP M5-Q52C-00, 01-00194-44, 2/23/01		$1,669,920	Pending receipt of contracting officer PNM; no planned resolution date available.
Review of Federal Supply Schedule Proposal Submitted by Abbott Laboratories, Diagnostic Division, Under Solicitation Number M5-Q52C-00, 01-00201-62, 3/28/01		$576,675	Pending receipt of contracting officer PNM; no planned resolution date available.
OFFICE OF FACILITIES MANAGEMENT (VHA)			
Review of Structural Design Problems at the New VA Regional Office, Bay Pines, FL, 8PE-E02-053, 3/16/98			Negotiations are continuing; no planned resolution date available.

APPENDIX C

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 B.

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	7
	Contract Review	7	
Less Than 6 Months	Internal Review	1	6
	Contract Review	5	
TOTAL			**13**

Tables 2 and 3 show a total of 11 reports that were unresolved as of September 30, 2001. This number differs from the 13 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 3/31/01	0	$0
Issued during reporting period	11	$4.3
Total Inventory This Period	**11**	**$4.3**
Management decision during reporting period		
Disallowed costs (agreed to by management)	11	$4.3
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Period	**11**	**$4.3**
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 3/31/01	34	$1,675.4
Issued during reporting period	21	$1,657.6
Total Inventory This Period	**55**	$3,333.0
Management decisions during reporting period		
Agreed to by management	22	$1,619.5
Not agreed to by management	22	$220.8
Total Management Decisions This Period	**44**	**$1,840.3**
Total Carried Over to Next Period	**11**	**$1,492.7**

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 D

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 Reqirements	Page
Section 4 (a) (2)	Review of legislation and regulations	65
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-73
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-73
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	89
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	78
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	79 to 85 (App. A)
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	90 (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	91 (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	87 (App. B)
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)	44

APPENDIX E

OIG OPERATIONS PHONE LIST

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West Palm Beach Resident Agency (51WP) West Palm Beach, FL ..... (561) 882-7720
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San Francisco Resident Agency (51SF) Oakland, CA ..... (510) 637-1074
Seattle Resident Agency (51SE) Seattle, WA ..... (206) 220-6654, ext 31

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OIG OPERATIONS PHONE LIST (CONT'D)

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APPENDIX F

GLOSSARY

CAP	Combined Assessment Program
CFS	Consolidated Financial Statements
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CY	Calendar Year
DAS	Data Analysis Section
DIC	Dependency and Indemnity Compensation
DoD	Department of Defense
EUL	Enhanced-Use-Lease
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FSS	Federal Supply Schedule
FOIA/PA	Freedom of Information Act/Privacy Act
FTE	Full Time Equivalent
FY	Fiscal Year
GID	Gender Identity Disorder
GPRA	Government Performance and Results Act
HEC	Health Eligibility Center
IG	Inspector General
IRS	Internal Revenue Service
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
PNM	Price Negotiation Memorandum
SSA	Social Security Administration
U.S.	United States
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VRE	Vocational Rehabilitation and Employment

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Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

The report is also available on our Web Site:

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Office of Inspector General
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