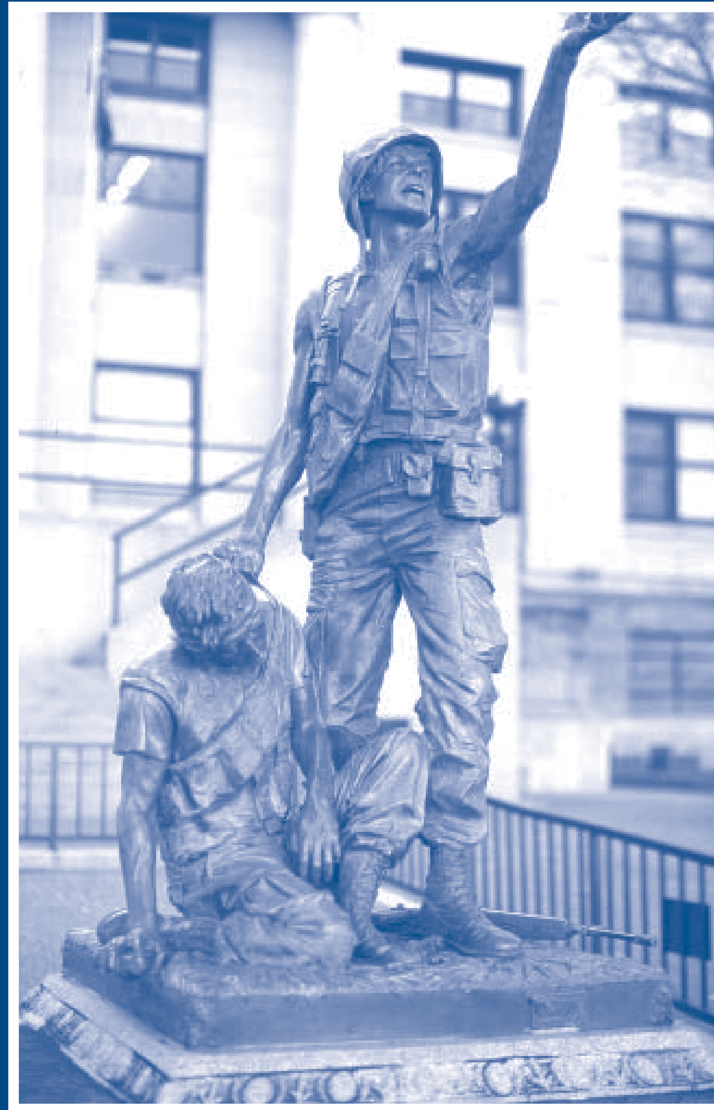


Office of Inspector General

Semiannual Report to Congress
April 1, 2003 - September 30, 2003

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, 2003. This report is issued in accordance with the provisions of the Inspector General Act of 1978, as amended. The OIG is dedicated to helping ensure that veterans and their families receive the care, support, and recognition they have earned through service to our country.

A total of 104 reports on VA programs and operations resulted in systemic improvements and increased efficiencies in areas of medical care, benefits administration, procurement, financial management, information technology, and facilities management. Audits, investigations, and other reviews identified $65.6 million in monetary benefits.

Our criminal investigators closed 439 investigations involving a wide variety of criminal activity directed at VA personnel, veterans, programs, or operations. During the semiannual period, we conducted investigations that led to 586 arrests, indictments, convictions, and pretrial diversions. In addition, criminal and administrative investigators, along with Hotline staff, accomplished 246 administrative sanctions. We provided investigative leads to other law enforcement agencies that directly resulted in 70 fugitive felon arrests nationwide. We produced $33.6 million in monetary benefits to VA (recoveries and savings). In one of our cases, a VA pharmacist was sentenced to 8 years' confinement and ordered to pay $500,000 for her role in stealing over 235,000 dosage units of schedule II and III controlled substances.

During this reporting period, two VA OIG special agents earned extraordinary honors by virtue of their work on three significant criminal investigations highlighted in our previous semiannual reports. In an unprecedented action, the Tampa chapter of the Military Order of the Purple Heart, an organization chartered by the U.S. Congress exclusively for combat-wounded veterans, presented the agents with National Commander Citation awards. Both agents distinguished themselves in the performance of their investigative duties. These cases involved the murder of a VA police officer, the death of a veteran due to an unauthorized drug injection, and a false claim made by a Korean war veteran that he was a prisoner of war and witnessed U.S. soldiers gunning down innocent civilians at No Gun Ri, Korea.

Our audit oversight of VA focused on determining how to improve service to veterans and their families. Audits, contract reviews, and other reviews saved or identified improved uses for $30.6 million. In addition, our audit of part-time physician time and attendance clearly showed that part-time physicians were not working the hours established in their VA appointments; thus, part-time physicians were not meeting their employment obligations to VA.

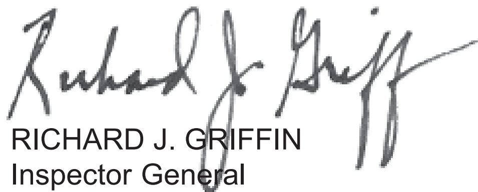
Our healthcare inspectors focused on quality of care issues in VA. An inspection of Veterans Health Administration facility Quality Management (QM) programs found that managers did not consistently analyze data collected for all quality improvement monitors. Significant QM actions

failed because existing tracking systems did not sufficiently ensure successful implementation of recommended QM actions. In a joint interagency report by the Offices of Inspectors General of the Departments of Agriculture, Defense, Energy, Health and Human Services, and VA, the OIGs found that, while senior officials from each agency had taken actions to improve security over biological agents, more needs to be done.

Our Hotline provides an opportunity for employees, veterans, and other concerned citizens to report criminal activity, waste, abuse, and mismanagement. The reporting of such issues is integral to the goal of improving the efficiency and effectiveness of the Government. During the reporting period, the Hotline received 7,194 contacts and opened 570 cases. Analysts closed 650 cases, of which 219 (33 percent) contained substantiated allegations. The monetary impact resulting from these cases totaled almost $1.4 million.

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 VA medical centers and VA regional offices on a cyclical basis. The 30 CAP reviews and 2 CAP summary reviews completed during this reporting period highlighted numerous opportunities for improvement in quality of care, management controls, and fraud prevention. 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 pursuit of world-class service for our Nation's veterans.



RICHARD J. GRIFFIN
Inspector General

On October 12, 1978, President Jimmy Carter created independent audit and investigative offices in 12 Federal agencies when he signed into law the Inspector General Act of 1978 (5 U.S.C. App.). One of these 12 agencies was in the Veterans Administration, which became the Department of Veterans Affairs in 1989.

The basic tenets of the Act have remained constant and strong over the past quarter century. Although amended several times to add new Inspectors General and clarify reporting requirements, the Act has given all Inspectors General the authority and responsibility to be independent voices for economy, efficiency, and effectiveness within the Federal Government. Today there are 29 presidentially appointed, Senate confirmed Inspectors General, who are members of the President's Council on Integrity and Efficiency. They protect the integrity of government, improve program efficiency and effectiveness, and prevent and detect fraud, waste, and abuse in Federal agencies. In keeping with the Act, Inspectors General keep their agency heads and the Congress fully and currently informed of the results of their work.

In remarks to VA Office of Inspector General employees on September 30, 2003, VA Secretary Anthony J. Principi recognized the contributions of the OIG with the following words:

> *The IG is my independent ally and VA's trusted partner, helping us achieve excellence in everything we do; your work is crucial to our process of continuous improvement. In every case, the results of the OIG's independent reviews of our daily operations yield valuable savings both in human and financial resources. At a time when our resources are constrained, every dollar we spend must be spent wisely. Every wasted dollar the OIG helps us identify and save is a dollar we can use in our mission of caring for America's veterans. I commend the OIG for your stewardship of both the public's trust and the public's dollar – you do our nation's veterans proud by holding yourselves, and your office, to the highest standards of government service.*

TABLE OF CONTENTS

Page

HIGHLIGHTS OF OIG OPERATIONS i
VA AND OIG MISSION, ORGANIZATION, AND RESOURCES 1
COMBINED ASSESSMENT PROGRAM 7
OFFICE OF INVESTIGATIONS
- Mission Statement 15
- Resources 15
- Criminal Investigations Division 15
  - Veterans Health Administration 16
  - Veterans Benefits Administration 19
  - Fugitive Felon Program 22
  - OIG Forensic Document Laboratory 23
- Administrative Investigations Division 24
  - Veterans Health Administration 25
  - Veterans Benefits Administration 25

OFFICE OF AUDIT
- Mission Statement 27
- Resources 27
- Overall Performance 27
  - Veterans Health Administration 28
  - Veterans Benefits Administration 31
  - Office of Management 32

OFFICE OF HEALTHCARE INSPECTIONS
- Mission Statement 35
- Resources 35
- Overall Performance 35
  - Veterans Health Administration 36

OFFICE OF MANAGEMENT AND ADMINISTRATION
- Mission Statement 43
- Resources 43
- Hotline Division 44
  - Veterans Health Administration 44
  - Veterans Benefits Administration 48
- Operational Support Division 49
- Information Technology and Data Analysis Division 51
- Financial and Administrative Support Division 54
- Human Resources Management Division 55

OTHER SIGNIFICANT OIG ACTIVITIES
- President's Council on Integrity and Efficiency 57
- OIG Management Presentations 57
- Awards and Special Thanks 58
- OIG Congressional Testimony 59

APPENDIX A - REVIEWS BY OIG STAFF 61
APPENDIX B - STATUS OF OIG REPORTS UNIMPLEMENTED FOR OVER 1 YEAR 71
  - Veterans Health Administration 72
  - Joint (Veterans Health Administration and Office of Security and Law Enforcement) 74
  - Veterans Benefits Administration 76

APPENDIX C - INSPECTOR GENERAL ACT REPORTING REQUIREMENTS 79
APPENDIX D - OIG OPERATIONS PHONE LIST 83
APPENDIX E - GLOSSARY 85

HIGHLIGHTS OF OIG OPERATIONS

This semiannual report highlights the activities and accomplishments of the VA OIG for the 6-month period ended September 30, 2003. The following statistical data highlights OIG activities and accomplishments during the reporting period and for the entire fiscal year (FY).

	Current 6 Months 4/1/03 - 9/30/03	FY 2003 10/1/02 - 9/30/03
DOLLAR IMPACT	**Dollar**	
Funds Put to Better Use	$49.4	$100.9
Dollar Recoveries	$10.5	$30.0
Fines, Penalties, Restitutions, and Civil Judgments	$5.7	$25.7
RETURN ON INVESTMENT		
Dollar Impact ($65.6) / Cost of OIG Operations ($27.2)	2 : 1	
Dollar Impact ($156.6) / Cost of OIG Operations ($60.5)		3 : 1
OTHER IMPACT		
Arrests	262	624
Indictments	189	349
Convictions	129	417
Pretrial Diversions	6	20
Fugitive Felon Lead Arrests	70	79
Administrative Sanctions	246	484
ACTIVITIES		
Reports Issued		
Combined Assessment Program (CAP) Reviews	30	42
CAP Summary Reviews	2	5
Joint Review	0	1
Audits	16	24
Contract Reviews	35	65
Healthcare Inspections	9	24
Administrative Investigations	12	21
Investigative Cases		
Opened	480	960
Closed	439	890
Healthcare Inspections Activities		
Clinical Consultations	13	28
Hotline Activities		
Contacts	7,194	14,728
Cases Opened	570	1,175
Cases Closed	650	1,307

OFFICE OF INVESTIGATIONS

Overall Focus

The Criminal Investigations Division focuses its resources on investigations that have the highest impact on the programs and operations of the Department. While continuing to target traditional "white collar" criminal activity associated with the operation of VA, personnel of the Criminal Investigations Division more frequently find themselves involved in the investigation of criminal activity such as fraud, drug diversion, theft, and murder - all of which can occur on VA property and/or directed at VA personnel, veterans, programs, or operations. The Administrative Investigations Division concentrates its resources on investigating allegations against high-ranking VA officials relating to misconduct and other matters of interest to Congress and the Department.

During this semiannual period, the Criminal Investigations Division closed 439 investigations resulting in 324 judicial actions (indictments, convictions, and pretrial diversions) and $33.6 million recovered or saved. Investigative activities resulted in the arrest of 262 individuals who had committed crimes directed at VA programs and operations or committed crimes on VA property. In addition, VA OIG provided investigative information to other law enforcement agencies leading to the arrest of 70 fugitive felons nationwide. Criminal investigations also resulted in 146 administrative sanctions. The Administrative Investigations Division closed 25 cases, issuing 12 reports and 5 advisory memoranda. These investigations resulted in management agreeing to take 25 administrative sanctions, including personnel actions against 15 officials, and corrective actions in 10 situations that will improve VA operations.

Veterans Health Administration (VHA)

A VA medical center (VAMC) supervisory pharmacist and her uncle were sentenced for their roles in a drug theft ring. The pharmacist was sentenced to 8 years' imprisonment, to be followed by 3 years' probation. She was also ordered to surrender $500,000 as part of her plea agreement. Her uncle was sentenced to 5 years, 10 months' imprisonment, to be followed by 3 years' probation. The investigation disclosed that the pharmacist stole over 235,000 dosage units of schedule II and III controlled substances from a VAMC. She then transferred those drugs to her uncle and others for street distribution. VA's loss was $194,000, and will be repaid to VA from the funds surrendered by the pharmacist. This was a joint investigation by the VA OIG and U.S. Drug Enforcement Administration (DEA).

Six individuals were charged with felony theft in a scheme in which several veterans' personal information was stolen from documents at a VAMC and fraudulently used to obtain credit cards, cable television services, and telephone services. The charges were the culmination of a 2½-year investigation. In mid-2001, seven other individuals were indicted, including the scheme's ringleaders, who obtained the personal data and used it to open lines of credit, and cable television and telephone service in numerous veterans' names. These seven ringleaders previously pled guilty and were each sentenced to 4 years' imprisonment. The six defendants recently charged were all recipients of the fraudulently obtained credit and other services. They

are pending further judicial action. The fraudulent credit purchases totaled nearly $80,000. VA police and the U.S. Postal Inspection Service assisted in this investigation.

Veterans Benefits Administration (VBA)

An individual pled guilty to wire fraud and aiding and abetting after a joint VA OIG and Department of Housing and Urban Development (HUD) OIG investigation disclosed that 2 individuals perpetrated a multi-state scheme to take advantage of more than 1,000 homeowners whose mortgages were in default and facing foreclosure. Of this number, 178 properties were subject to mortgages guaranteed by the Government. The subjects contacted the distressed homeowners assuring them that they could "buy them some time" before foreclosure. The subjects then collected rent and fees from the homeowners but failed to make any payments on existing mortgages. As part of the scheme, they used fictitious names and Social Security numbers and filed more than 200 fraudulent bankruptcies to delay the foreclosure process. The subjects wrongfully collected $51,000 in rent and fees. The total loss to the Government was $390,000.

Anchorage Daily News
Anchorage, AK
Wednesday, August 13, 2003

ANCHORAGE

Man who bilked veterans agency pleads guilty, faces 30 years

An Anchorage veteran pleaded guilty last week to scamming the U.S. Department of Veteran Affairs of $450,000 in fake bus repairs, according to the U.S. Attorney's Office.

Federal prosecutors said Ronald L. Phillips is a veteran who claimed a disability and then qualified for financial assistance under the Veterans Affairs Vocational Rehabilitation Self-Employment program.

He submitted bids to have two of the buses from his transportation company, Alaska Tour Quest, refurbished by a Palmer company, according to the indictment.

Phillips then turned in fake invoices worth more than $450,000 for repairs that were never made and instead used the money to buy more buses, the indictment says.

He pleaded guilty in U.S. District Court Thursday to wire fraud and conspiracy to commit mail and wire fraud. He faces a maximum sentence of 30 years in prison and a $1 million fine for the fraud charge and possible restitution.

Anchorage Daily News

A veteran and co-conspirator pled guilty to charges of wire fraud, mail fraud, and conspiracy relating to a scheme to defraud VA's Vocational Rehabilitation and Employment program. The veteran, as a part of his rehabilitation, requested VA to pay for the refurbishment of two buses he would use in a newly established guided tour business. Accordingly, VA paid the veteran almost $450,000 for refurbishing buses, marketing, and other business expenses. However, contrary to the approved plan, the veteran unlawfully used the funds to purchase 28 buses. He submitted fraudulent invoices and work orders to VA to facilitate the scheme.

Seven active duty sailors with the U.S. Navy conspired to defraud VA's Tuition Assistance Top Up program of almost $400,000. The program is designed to allow participating active duty service personnel to use Montgomery GI Bill benefits to pay the difference between the cost of tuition and the amount paid by the military's active duty tuition assistance program. The scheme developed when the primary subject filed claims and received payments from VA for classes he never attended. This subject was in the unique position of having access to naval personnel records and knowledge of the program. The subject exploited weaknesses he discovered in the program's administration to commit the fraud. He also convinced other sailors to participate in the scheme. A grand jury charged the subject and six co-conspirators with conspiracy, theft of Government funds, and aiding and abetting.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for $30.6 Million

Audits and evaluations were focused on operations and performance results to improve service to veterans. Contract preaward and postaward reviews were conducted to assist contracting officers in price negotiations and to ensure reasonableness of contract prices. During this reporting period, 83 audits, evaluations, CAP reviews, CAP summary reviews, and contract preaward and postaward reviews were conducted that identified opportunities to save or make better use of $30.6 million.

Veterans Health Administration

Our audit of part-time physician time and attendance showed that part-time physicians were not working the hours established in their VA appointments, and as a result, part-time physicians were not meeting their employment obligations to VA. Also, an audit of VHA reported medical care waiting lists showed that the waiting lists were not accurate.

Office of Management

We issued eight management letters addressing financial reporting and control issues as part of the annual consolidated financial statements audit. The management letters provided Department management 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 2002 consolidated financial statements, but correction of the conditions was considered necessary for ensuring effective operations.

OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections (OHI) participated with the Offices of Audit and Investigations on 23 CAP reviews and reported on specific clinical issues warranting the attention of VA managers. We reviewed health care issues and made 58 recommendations and 49 suggestions to improve operations, activities, and the care and services provided to patients.

Our inspection of VHA facility QM programs found that facility managers did not consistently analyze data collected for all quality improvement monitors or benchmark their results. Some significant QM actions failed because existing tracking systems did not sufficiently ensure successful implementation of recommended QM actions. Clinical managers did not always consider QM results in their biennial reprivileging decisions, and many facilities had not established acceptable methods for analyzing mortality data.

To address security controls over biological agents subsequent to the anthrax mailings, the Offices of the Inspectors General of the Departments of Agriculture, Defense, Energy, Health and Human Services, and VA formed an interagency committee to ensure close coordination of audits, evaluations, and inspections. The OIGs issued an interagency summary report on security

controls over biological agents that summarized issues identified in 26 reports published by the 5 committee-member agencies and 1 report published by the Army Inspector General from February 2, 2001 through April 16, 2003. The VA OIG published one of these reports. The summary report concluded that senior officials at each agency had taken actions to improve security controls over biological agents in response to the published reports, but more needs to be done.

In responding to congressional and other special requests and reviewing patient allegations pertaining to quality of care issues received by the OIG Hotline, we completed 17 Hotline cases, reviewed 55 issues, and made 21 recommendations. These recommendations resulted in managers issuing new and revised procedures, improving services, improving quality of patient care, and making environmental and safety improvements. OHI assisted the Office of Investigations on 13 criminal cases that required reviews of medical evidence, and monitored the work of VHA's Office of the Medical Inspector.

OFFICE OF MANAGEMENT AND ADMINISTRATION

Hotline

Our Hotline provides an opportunity for employees, veterans, and other concerned citizens to report criminal activity, waste, abuse, and mismanagement. During the reporting period, the Hotline received 7,194 contacts and opened 570 cases. Analysts closed 650 cases, of which 219 (33 percent) contained substantiated allegations. The monetary impact resulting from these cases totaled almost $1.4 million. The Hotline staff wrote 127 responses to inquiries received from Members of the Senate and House of Representatives. The closed cases led to 75 administrative sanctions against employees and 128 corrective actions taken by management to improve VA operations and activities. Examples of some of the cases addressed by the Hotline include: (i) identity issues, (ii) privacy/Health Insurance Portability and Accountability Act issues, (iii) time and attendance issues, (iv) patient care issues, and (v) benefits issues.

Follow Up on OIG Reports

The Operational Support Division continually tracks VA staff actions to implement recommendations made in OIG audits, inspections, and reviews. As of September 30, 2003, there were 71 open OIG reports containing 255 unimplemented recommendations with over $903 million of actual or potential monetary benefits. During this reporting period, we closed 78 reports and 502 recommendations, with a monetary benefit of $241 million, after obtaining information that VA officials had fully implemented corrective actions.

Status of OIG Reports Unimplemented for Over 1 Year

The Federal Acquisition Streamlining Act of 1994 provides guidance on prompt management decisions and implementation of OIG recommendations. It states a Federal agency shall complete final action on each recommendation in an OIG report within 12 months after the report is finalized. If the agency fails to complete final action within this period, the OIG will identify the matter in their semiannual report to Congress. There are eight OIG reports issued over 1 year

ago (September 30, 2002, and earlier) with unimplemented recommendations. Four of these are VHA reports; one is a joint report with recommendations for VHA and Office of Security and Law Enforcement, Office of Policy, Planning, and Preparedness; and three are VBA reports. The OIG is particularly concerned with two reports on VHA operations (issued in 1997 and 1999) and two reports on VBA operations (both issued in 2000) with recommendations that still remain open. Details about these reports can be found in Appendix B.

VA AND OIG MISSION, ORGANIZATION, AND RESOURCES

The Department of Veterans Affairs

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 our 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 income and readjustment 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; and Acquisition and Materiel Management [A&MM]);
- Information and Technology (I&T);
- Policy, Planning, and Preparedness (Policy; Planning; and Security and Law Enforcement [S&LE]);
- Human Resources and Administration (Diversity Management and Equal Employment Opportunity; Human Resources Management; Administration; and Resolution Management);

- Public and Intergovernmental Affairs; and
- Congressional and Legislative Affairs.

In addition to VA's OIG, 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, the Office of Employment Discrimination Complaint Adjudication, and the Office of Regulation Policy and Management.

Resources

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For FY 2003, VA had approximately 212,000 employees and a $60.4 billion budget. There are an estimated 25.6 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 193,000 of VA's employees work in VHA. Health care was funded at over $26.2 billion in FY 2003, approximately 43 percent of VA's budget. VHA provided care to an average of 59,000 inpatients daily. During FY 2003, there were almost 51 million episodes of care for outpatients. There were 160 hospitals, 133 nursing home units, 206 veterans centers, 43 domiciliaries, and 847 outpatient clinics (including hospital clinics).

Veterans benefits were funded at $33.6 billion in FY 2003, about 55 percent of VA's budget. Approximately 13,000 VBA employees at 57 VA regional offices (VAROs) provided benefits to veterans and their families. Almost 2.8 million veterans and their beneficiaries received compensation benefits valued at $25.5 billion. Also, $3.3 billion in pension benefits were provided to veterans and survivors. VA life insurance programs had 7.4 million policies in force, with a face value of over $747.3 billion. Approximately 500,000 home loans were guaranteed in FY 2003, with a value of almost $64 billion.

The NCA operated and maintained 120 cemeteries and employed over 1,400 staff in FY 2003. Operations of NCA and all of VA's burial benefits account for approximately $410 million of VA's budget. Interments in VA cemeteries continue to increase each year, with 89,755 for FY 2003. Approximately 344,800 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 audits and investigations 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 criminal activity, waste, abuse, and mismanagement in VA programs and operations; 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 revised and expanded procedures 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 special reviews.

Organization

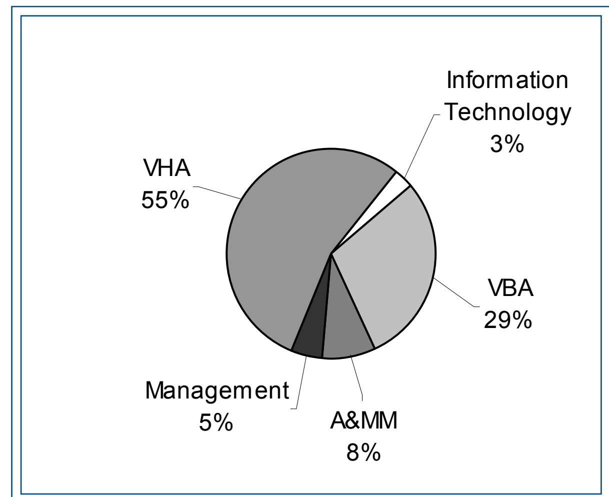
Allocated full-time equivalent (FTE) employees from appropriations for the FY 2003 staffing plan are shown below.

OFFICE	ALLOCATED FTE
Inspector General	4
Counselor	4
Investigations	136
Audit	176
Management and Administration	57
Healthcare Inspections	46
TOTAL	**423**

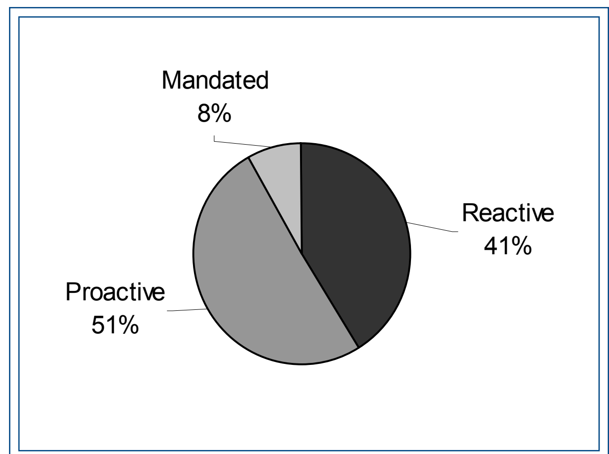
In addition, 25 FTE are reimbursed for a Department contract review function.

The FY 2003 funding for OIG operations was enacted as a 2-year appropriation that provides the funds to remain available until September 30, 2004. The FY 2003 funding for OIG operations was $60.5 million, with $57.6 million from appropriations and $2.9 million through a reimbursable agreement. Approximately 76 percent of the total funding was for salaries and benefits, 4 percent for official travel, and the remaining 20 percent for all other operating expenses such as contractual services, rent, supplies, and equipment.

OIG resource allocation, by VA organizational element, during this reporting period, is shown as follows.



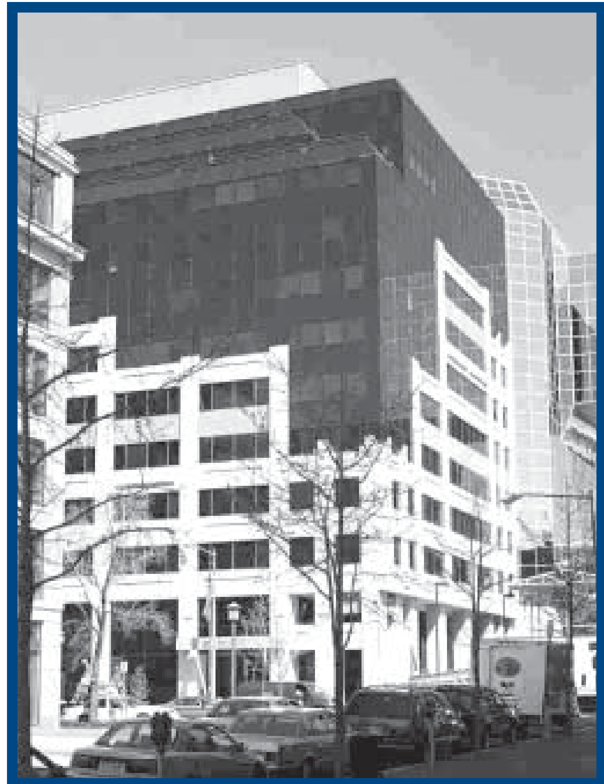
OIG resource allocation applied to mandated, reactive, and proactive work is shown below.



Mandated work is required by statute or regulation. Examples include our audits of VA's consolidated financial statements, oversight of VHA's quality management programs and Office of the Medical Inspector, follow up activities on OIG reports, and releases of Freedom of Information Act (FOIA) information.

Reactive work is generated in response to requests for assistance received from external sources concerning allegations of criminal activity, waste, abuse, and mismanagement. Most of the Office of Investigations' work is reactive.

Proactive work is self-initiated, focusing on areas where the OIG staff determines there are significant issues.



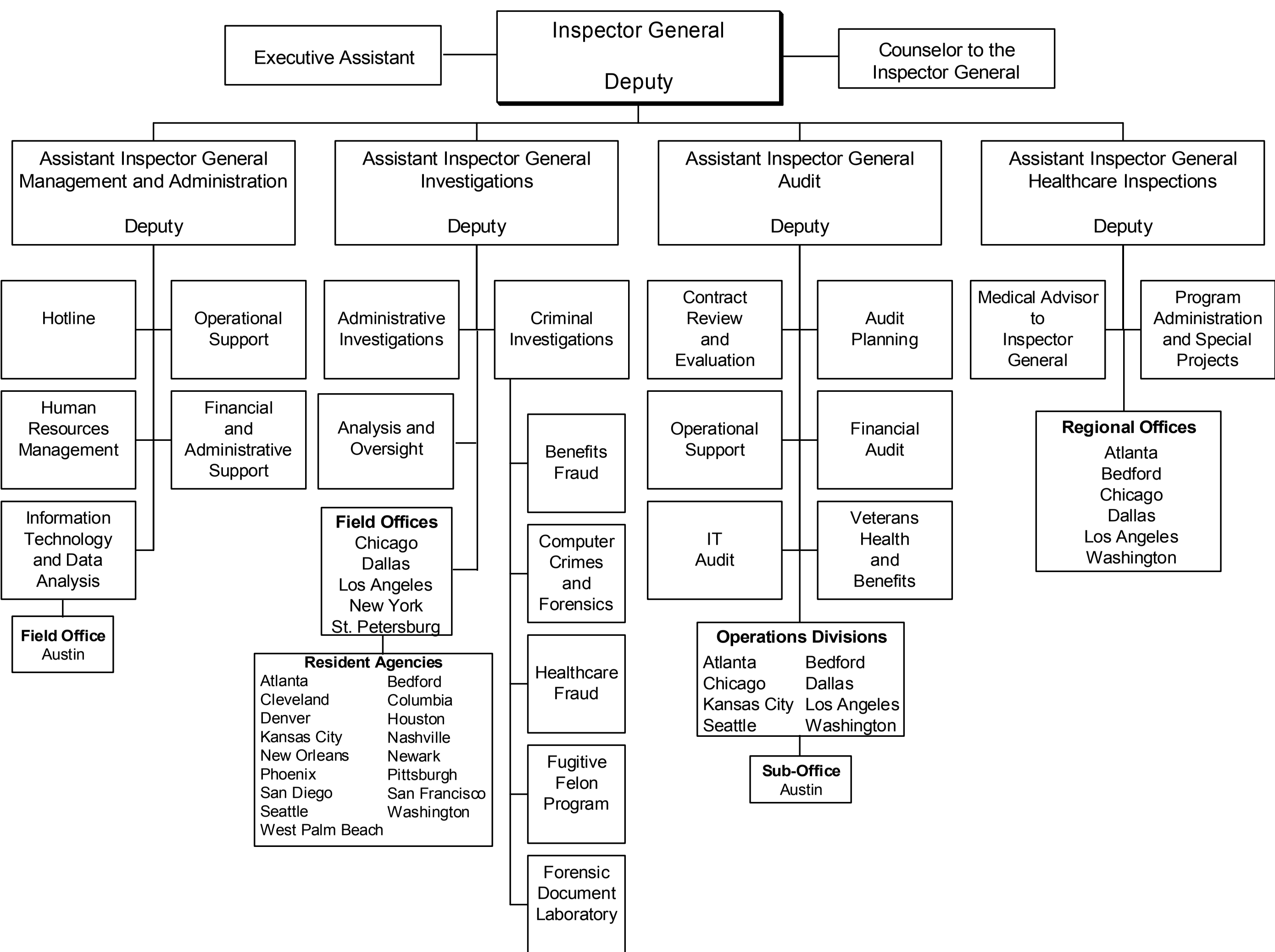
TechWorld, home to the VA Office of Inspector General

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 healthcare inspections to promote economy, efficiency, and effectiveness in VA activities, and to detect and deter criminal activity, 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 to perform their duties fairly, honestly, and with the highest professional integrity.


Department of Veterans Affairs
Office of Inspector General
Inspector General
Deputy
Executive Assistant
Counselor to the Inspector General
Assistant Inspector General Management and Administration
Deputy
Hotline
Operational Support
Human Resources Management
Financial and Administrative Support
Information Technology and Data Analysis
Field Office
Austin
Assistant Inspector General Investigations
Deputy
Administrative Investigations
Criminal Investigations
Analysis and Oversight
Field Offices
Chicago
Dallas
Los Angeles
New York
St. Petersburg
Resident Agencies
Atlanta
Cleveland
Denver
Kansas City
New Orleans
Phoenix
San Diego
Seattle
West Palm Beach
Bedford
Columbia
Houston
Nashville
Newark
Pittsburgh
San Francisco
Washington
Benefits Fraud
Computer Crimes and Forensics
Healthcare Fraud
Fugitive Felon Program
Forensic Document Laboratory
Assistant Inspector General Audit
Deputy
Contract Review and Evaluation
Audit Planning
Operational Support
Financial Audit
IT Audit
Veterans Health and Benefits
Operations Divisions
Atlanta
Chicago
Kansas City
Seattle
Bedford
Dallas
Los Angeles
Washington
Sub-Office
Austin
Assistant Inspector General Healthcare Inspections
Deputy
Medical Advisor to Inspector General
Program Administration and Special Projects
Regional Offices
Atlanta
Bedford
Chicago
Dallas
Los Angeles
Washington

COMBINED ASSESSMENT PROGRAM

Reports Issued

During the period April 1, 2003 through September 30, 2003, we issued 30 CAP reports. Of the 30 CAP reports, 23 were for VA health care systems and VAMCs; 7 were for VAROs. We also issued 2 CAP summary reports during this period.

Combined Assessment Program Overview - Medical

CAP reviews are part of the OIG's efforts to ensure that quality health care services are provided to our Nation's veterans. CAP reviews provide cyclical oversight of VAMC operations, focusing on the quality, efficiency, and effectiveness of services provided to veterans by combining the skills and abilities of representatives from the OIG Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA health care systems.

Healthcare inspectors conduct proactive reviews to evaluate care provided in VA health care facilities and assess the procedures for ensuring the appropriateness of patient care and the safety of patients and staff. 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 management concern, which are derived from a concentrated and continuing analysis of VHA, Veterans Integrated Service Network (VISN), and VAMC databases and management information. Areas generally covered include procurement practices, financial management, accountability for controlled substances, and information security.

Special agents conduct fraud and integrity awareness briefings. The purpose of these briefings is to provide VAMC employees with insight into the types of fraudulent and other criminal activities that can occur in VA programs and operations. The briefings include an overview and case-specific examples of fraud and other criminal activities. Special agents may also investigate certain matters referred to the OIG by VA employees, Members of Congress, veterans, and others.

During this period, we issued 23 health care facility CAP reports. See Appendix A for the full title and date of the CAP reports issued this period. These 23 reports relate to the following VA medical facilities:

- VAMC Fayetteville, Arkansas
- VAMC San Francisco, California
- VAMC Washington, District of Columbia
- VAMC Bay Pines, Florida
- James A. Haley VAMC, Tampa, Florida
- VAMC Augusta, Georgia
- VA Illiana Healthcare System, Danville, Illinois
- VAMC Marion, Illinois
- VAMC North Chicago, Illinois
- VA Iowa City Healthcare System, Iowa
- VAMC New Orleans, Louisiana
- Overton Brooks VAMC, Shreveport, Louisiana
- Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts
- VAMC Iron Mountain, Michigan
- VA Sierra Nevada Healthcare System, Reno, Nevada
- VA Hudson Valley Healthcare System, Montrose, New York

- VAMC Asheville, North Carolina
- VA Roseburg Healthcare System, Oregon
- VAMC Butler, Pennsylvania
- VAMC Houston, Texas
- Jonathan W. Wainwright Memorial VAMC, Walla Walla, Washington
- VAMC Huntington, West Virginia
- Clement J. Zablocki VAMC, Milwaukee, Wisconsin

> ***"We appreciated the opportunity for the OIG to evaluate the programs of the VAMC through the CAP. The survey team provided helpful guidance to our staff in an educational and productive manner. As we are a continuously improving organization, we welcome their recommendations and suggestions that will only help us to become a better organization. Thank you."***
>
> **Director, VAMC Walla Walla, WA**

Summary of Findings

Deficiencies identified during prior CAP reviews relating to management of veterans health care programs were discussed in two recently issued OIG summary reports. During this reporting period, we identified similar problems at the 23 facilities.

Procurement

We reported the need to improve VA procurement practices as one of the Department's most serious management challenges. We continue to identify control weaknesses in this area during CAP reviews. Controls need to be strengthened to: (i) effectively administer the Government purchase card program, (ii) improve service contract controls, (iii) improve contract administration, and (iv) strengthen inventory management.

- Government purchase card controls were deficient at 17 of 21 facilities where we tested these controls. Policy and procedures governing the use of purchase cards, setting purchasing limits, and accounting for purchases were not followed.

- Service contract controls were deficient at 7 of 13 facilities where we tested these issues. Controls needed to be strengthened to ensure that: (i) acquisition and materiel management staff determine price reasonableness in noncompetitive contracts, (ii) contract provisions include procedures to help ensure contract compliance, and (iii) contracting officials monitor contract performance.

- Medical supply inventory management was deficient at 9 of the 11 facilities where we tested these issues, and nonmedical inventory management was deficient at 3 of 7 facilities where we tested these issues. We found that inventory levels exceeded current requirements resulting in funds being tied up in excess inventories. Also, we found that nonmedical inventories were either not performed or inaccurate.

Information Technology

A wide range of automated information system vulnerabilities were identified that could lead to misuse or destruction of critical sensitive information. VA had established comprehensive information security policies, procedures, and guidelines; however, CAP reviews found that facility policy development, implementation, and compliance were inconsistent. In addition, there was a need to improve access controls, contingency planning, incident reporting, and security training.

We found inadequate management oversight contributed to inefficient practices, and to

inadequate information security and physical security of assets. CAP findings complement the results of our FY 2002 Government Information Security Reform Act audit, which identified information security vulnerabilities that place the Department at risk of: (i) denial of service attacks on mission critical systems, (ii) disruption of mission critical systems, (iii) unauthorized access to and improper disclosure of data subject to Privacy Act protection and sensitive financial data, and (iv) fraudulent payment of benefits.

- Information technology (IT) security deficiencies were found at 21 of the 23 VHA sites visited. We found that: (i) security plans were not prepared or not kept current and lacked key elements, (ii) access to VHA's Veterans Health Information Systems and Technology Architecture was not effectively monitored, and/or (iii) background investigations were not conducted on contract personnel working in sensitive areas.

Controlled Substances

- VA has established policies, procedures, and guidelines for accountability of controlled substances and other drugs. However, controlled substance inspection procedures were inadequate to ensure compliance with VHA policy and U.S. Drug Enforcement Administration (DEA) regulations at 17 of 23 facilities visited. Unannounced inspections and inventories were not properly conducted, unusable drugs were not disposed of timely or properly, and discrepancies between inventory results and recorded balances were not reconciled in a timely manner. The lack of management oversight at facility and VISN levels contributed to inefficient practices and to weaknesses in drug accountability.

Medical Care Collections Fund

- VA has increased Medical Care Collection Fund collections. However, we found deficiencies at 4 of 12 facilities where we tested these issues. Facility management needs to strengthen billing procedures to avoid missed billing opportunities.

Pharmacy Security

- VA needs to improve physical security in pharmacy areas. We found physical security deficiencies in pharmacy areas at 5 of 12 facilities where we tested these issues.

VA Medical Center
Augusta, GA

Part-Time Physician Time and Attendance

- VAMC managers did not have effective controls in place to ensure that part-time physicians were on duty when required by employment agreements at three of six facilities where we tested these controls. Physicians did not complete appropriate time and attendance records, and timecards were not posted based on the timekeepers' actual knowledge of physicians' attendance. Additionally, timekeepers did not receive annual refresher training, and desk audits were not conducted, as required by VA policy.

Health Care Management

- We reviewed VHA's policies and practices for managing violent patients at 13 medical facilities. We found that while each facility had a policy that described emergency response procedures to violent patient episodes, only seven of the policies identified interdisciplinary response teams, while

the remaining six identified either police officers or nursing employees as responders. Facilities used two separate systems to report incidents of patient violence resulting in inconsistent or incomplete data collection. Additionally, the two systems did not interface, and access to the databases was restricted to a small cadre of employees. While 12 facilities had policies indicating that they had committees to review violent incidents, make decisions regarding dispositions of the patient perpetrators, and regularly follow-up on their decisions, we found only 5 facilities had committees that actually fulfilled these functions.

Survey Results

Inpatient Surveys

We completed 344 inpatient interviews in 23 VHA facilities during this semiannual period. We surveyed patients in the areas of medicine, surgery, intensive care, mental health, nursing home, domiciliary, and special emphasis programs.

> ***"I am pleased with the outcome of the review and the affirmation that the VAMC provides high quality health care to our Nation's veterans. Also significant are the high levels of patient and employee satisfaction that were noted by the audit team. Please express my appreciation to the auditors and support staff who conducted the review for their professionalism and efforts to assist in improving the medical center's operations and controls."***
>
> **Director, VAMC Houston, TX**

- In comparing patient responses for the current period to the prior semiannual report, we observed higher levels of satisfaction in 10 of the 18 areas surveyed that included timeliness, education, involvement, and continuity of care. Areas with significantly higher levels of satisfaction were those involving receiving medication and treatment to reduce pain, receiving instructions on how to use medical equipment, and being satisfied with their medical care plans. In contrast, ensuring patient privacy during conversations with their clinicians was identified as significantly lower, suggesting an area of concern for future reviews. Ninety-four percent of patients would recommend VA medical care to eligible family members or friends, and 95 percent rated the quality of care to be good, very good, or excellent. Results of these findings were discussed with facility managers during site visits.

Outpatient Surveys

We surveyed 325 VA outpatients at 23 facilities to ascertain their satisfaction with the care that they received. We interviewed patients in the primary care, mental health, and specialty care clinics. We also surveyed outpatients who were in waiting areas of the various supportive services such at pharmacy, radiology, and laboratory.

- In comparing responses for the current period to the prior semiannual report, we observed higher levels of patient satisfaction in 8 of the 18 areas surveyed that included timeliness, access to care, and education about care. Areas with significantly higher levels of satisfaction were patients who indicated receiving refills before running out of medicine, obtaining an appointment with a specialist within 30 days of referral, receiving education from primary care providers about new medications, and the adequacy of signage in medical facilities. In contrast, two satisfaction indices concerning VA personnel addressing their treatment needs to their satisfaction, and their being seen within 30 minutes of arrival to appointments were identified as significantly lower than the previous time period. Not receiving an explanation regarding delays when arriving at appointments obtained the lowest score. Ninety-six percent rated the quality of care to be good,

very good, or excellent; an equal number would recommend VA medical care to eligible family members or friends. Results of these findings were discussed with facility managers during site visits.

Physical Plant Environment

We inspected 166 areas at 17 facilities including primary care and specialty outpatient clinics, inpatient wards, emergency rooms, intensive care/ coronary care units, nursing home units, psychiatry units, and rehabilitation areas.

- Overall, we found that all facilities were generally clean and well maintained. While minor cleanliness and sanitation problems were identified at all facilities, managers took immediate actions to correct identified deficiencies. However, we found that some managers needed to improve processes to ensure unobstructed hallways, secure chemical storage areas and medications, ensure patient privacy and security, and keep patient nourishment areas clean. At some facilities, emergency evacuation plans were not posted in all high-visibility areas and inpatient units.

- At 15 facilities we inspected nutrition and food service areas and retail stores for environment of care concerns. We inspected 19 facility kitchens and 13 canteen kitchens. We found that improvements in cleanliness and maintenance were needed in the main hospital kitchens and the canteen kitchens. Some managers needed to improve overall cleanliness of the kitchens; specifically, actions needed to be taken to replace broken or soiled ceiling tiles, ensure trash containers are properly covered, and confirm that refrigerated cases and freezers are kept clean and maintained at proper temperatures. In addition, some facilities did not have emergency eye wash stations in the kitchen areas, and refrigerators not in use were not secured with locking systems.

Employee Surveys

We surveyed employees at 19 facilities during this semiannual period using a web-based questionnaire. We discussed the results of these surveys with managers during each site visit.

Overton Brooks VA Medical Center
Shreveport, LA

- Seventy-eight percent of the respondents believed that high quality care was the first priority at their facilities. Seventy-eight percent also believed that the quality of care at their facilities was good or excellent.

- Eighty-five percent of responding employees asserted that they received proper orientation and training to do their jobs, and 62 percent believed they were provided with opportunities to fulfill their continuing education needs. However, 46 percent of respondents indicated they had not been offered opportunities for career advancement.

- Fifty-six percent of respondents believed that adverse events were thoroughly investigated.

- Thirty-four percent of respondents indicated that housekeeping support was inadequate to maintain patient safety and general cleanliness, and 37 percent reported that work orders for needed repairs were not addressed promptly.

Combined Assessment Program Overview - Benefits

During this period, we issued seven CAP reports on the delivery of benefits. See Appendix A for the full title and date of the CAP reports issued this period. These seven reports relate to operations at the following VAROs:

- VARO Los Angeles, California
- VARO St. Petersburg, Florida
- VARO Atlanta, Georgia
- VARO Chicago, Illinois
- VARO St. Paul, Minnesota
- VARO St. Louis, Missouri
- VARO Muskogee, Oklahoma

VA Regional Office
Atlanta, GA

Summary of Findings

The following areas required the attention of VBA management.

Information Technology

The increased CAP review coverage of VBA facilities in FY 2003 identified a wide range of vulnerabilities in VBA systems similar to those we identified during VHA CAP reviews. The deficiencies could lead to misuse or loss of sensitive automated information and data. The CAP review findings show a need to improve access controls, contingency planning, risk assessments, and security training. Inadequate management oversight contributed to inadequate information security and physical security of assets.

- IT security was deficient at six of seven offices reviewed. Risk assessments needed to be conducted, and some contingency plans required revision and testing.

- VARO management needed to strengthen security over the Beneficiary Delivery Network (BDN) at one of six offices where we tested security controls. BDN is the computerized system that VAROs use to process benefit claims. BDN security controls are intended to protect the privacy of personal data and prevent fraudulent use of the system. At one VARO, the information security officer did not manage BDN access in accordance to VBA requirements.

Compensation and Pension Claims Processing

- Timeliness of compensation and pension (C&P) claims processing needed improvement at all five offices where we tested C&P processing. C&P claims had avoidable processing delays and/or procedural errors that affected workload and timeliness measures. Managers need to monitor the effectiveness of recent initiatives to improve claims processing timeliness and provide refresher claims processing training for veteran service center staff.

- Deficiencies were noted at two of the seven offices visited involving the third-signature authorization control on C&P one-time payment awards.

- Other C&P deficiencies found during our visits included inaccurate actions on system error messages, inaccurate entry of data, and improper reduction by veteran service center personnel of pension benefits of veterans hospitalized for extended periods at Government expense.

Other VBA Programs

- Government purchase card program deficiencies existed at all five facilities where we tested the program controls. Supervisory approvals and certifications were not performed, single purchase limits were exceeded, and purchase card duties were not separated.

- We found that improvements were needed in fiduciary accounting and field examination controls and procedures at six of the seven offices where we tested these issues. Management needed to improve the oversight of incompetent beneficiaries' funds by ensuring field examinations were conducted and appropriate corrective action was taken. Also, fiduciary accountings were not always submitted timely or accurately.

- VBA's processing and timeliness over vocational rehabilitation and employment claims needed improvement. Data entry, claims processing, and case monitoring errors were noted at five of the six offices where we tested these issues. Management needs to process claims for vocational rehabilitation benefits in a timely manner, enter accurate data, and monitor claims status.

- Loan administration activities were reviewed at two regional loan centers. At one regional loan center, we found lender files that did not contain records of lender performance or documentation of servicing deficiencies.

- Educational assistance program deficiencies were noted at three offices. At two offices, the regional processing office did not schedule and complete all compliance surveys as required. At another office, incorrect dates of receipt were recorded for some education claims and some undocumented claims were recorded as completed.

VA Regional Office
Los Angeles, CA

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 consists of three divisions.

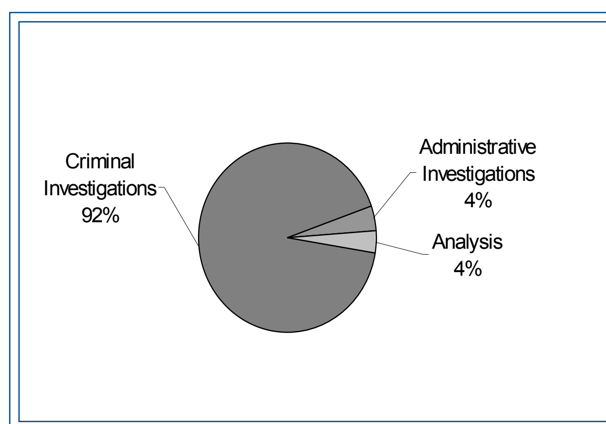
I. Criminal Investigations – The Division is primarily responsible for conducting investigations into allegations of criminal activities related to the programs and operations of VA. Criminal violations are referred to the Department of Justice for prosecution. The Division is also responsible for operation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

II. Administrative Investigations – 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 – 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 136 FTE allocated to the following areas.



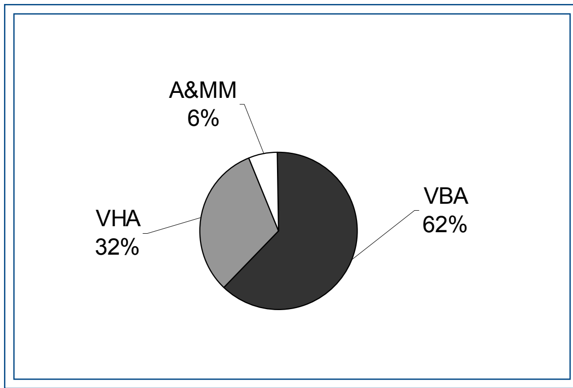
I. CRIMINAL INVESTIGATIONS DIVISION

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 121 FTE allocated for its headquarters and 22 field locations. These individuals are deployed in the following VA program areas.



Overall Performance

Output

- 439 investigations were concluded during the reporting period.

Outcome

- Arrests - 262
- Indictments -189
- Convictions - 129
- Pretrial Diversion - 6
- Fugitive Felon Lead Arrests - 70 (arrests of fugitive felons effected by other law enforcement agencies as a direct result of investigative leads provided by the VA OIG)
- Administrative Sanctions - 146
- Monetary benefits - $33.6 million ($5.7 million - fines, penalties, restitutions, and civil judgments; $26 million - efficiencies/funds put to better use; and $1.9 million - recoveries)

Customer Satisfaction

- Customer satisfaction was 4.9 on a 5 point scale.

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 Division 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 VAMCs. During this semiannual period, OIG special agents have participated in/or provided support to VA police in the arrest of 43 individuals who committed crimes on VHA properties.

Electronic Crimes

- A former VA employee pled guilty to possession of child pornography and was sentenced to 27 months' imprisonment, to be followed by 3 years' probation. In addition, the subject was ordered to submit a DNA sample, required of all convicted sex offenders. A joint investigation with VA police disclosed the employee, during duty hours, downloaded child pornography from the Internet onto a VA computer.

Theft/Diversion of Pharmaceuticals

- A group of veterans was found to be involved in a scheme in which each fraudulently obtained narcotics from various VAMCs. These veterans then sold the tablets for $1 each to the primary suspects in this case, two other veterans, who re-sold the tablets for $4 each "on the street." Investigation revealed the two primary suspects, an uncle and his nephew, were involved in a multi-state distribution ring of oxycodone tablets. Both were arrested while enroute to another state with 4,300 tablets under the hood of their car. The estimated street value of the seized narcotics was $43,000. Their vehicle was seized and forfeited pursuant to Federal drug forfeiture laws. The

nephew previously pled guilty to distribution of narcotics and was sentenced to 21 months' imprisonment. The uncle recently pled guilty to distribution of narcotics and is pending sentencing. This was a joint investigation by VA OIG, DEA, and two county sheriffs' departments.

- A VAMC supervisory pharmacist and her uncle were sentenced for their roles in a drug theft ring. The pharmacist was sentenced to 8 years' confinement, to be followed by 3 years' probation. She was also ordered to surrender $500,000 as part of her plea agreement. Her uncle was sentenced to 5 years, 10 months' imprisonment, to be followed by 3 years' probation. The investigation disclosed that the pharmacist stole over 235,000 dosage units of schedule II and III controlled substances from a VAMC. She then transferred those drugs to her uncle and others for street distribution. VA's loss was $194,000 and will be repaid to VA from the funds surrendered by the pharmacist. This was a joint investigation by the VA OIG and DEA. Additional arrests are expected.

Possession of Illegal Drugs

- A task force comprised of law enforcement personnel from the VA OIG, DEA, and local police arrested 14 individuals, based on a VA OIG investigation that identified numerous illegal drug transactions that occurred at a VAMC and other locations. The individuals face charges of distribution of controlled substances within 1,000 feet of a public school. Four additional arrest warrants remain outstanding. In addition to drugs, the three search warrants executed in this case yielded drug paraphernalia and firearms.

Embezzlement

- Two former employees of a credit union located at a VAMC pled guilty to bank fraud and credit union larceny. One of the employees was sentenced to 6 months' incarceration and 3 years' supervised release and ordered to pay restitution of $37,677. Sentencing is pending for the second employee. An independent audit of the credit union's records determined that $68,900 had been withdrawn fraudulently. Electronic password histories indicated passwords issued to the two employees were used to gain access to the missing funds. The withdrawals, taken sporadically by the employees, totaled $31,223 and $37,677, respectively. Both employees admitted to logging fabricated transactions in order to conceal the theft of funds. The employees resigned their positions immediately prior to the audit.

Theft of Benefits

- A former VAMC licensed practical nurse was sentenced to 5 years' probation and ordered to pay $12,371 restitution and to refrain from filing or re-filing a Federal workers' compensation claim regarding latex allergies. The nurse had previously pled guilty to theft of Government monies. Investigation revealed the nurse filed a compensation claim alleging that she had a latex allergy so severe that she feared "anaphylaxis and possible death." In order to accommodate her alleged latex allergy, the VAMC created a position that allowed her to work out of her home and continue to receive her full salary. The VAMC subsequently learned the nurse had obtained another job as a nurse at a private nursing home with a tremendous amount of latex exposure. The nurse never notified VA or the U.S. Department of Labor, Office of Workers' Compensation Program (where she had a pending claim for her latex allergy) of her new employment. The investigation also determined that both VA and the private nursing home were paying the nurse for some of the same hours. The nurse resigned her VA position. The loss to VA was $12,371 for the time card fraud and $60,170 for the salary that the nurse was paid to work out of her home.

- A former VAMC registered nurse was sentenced to 18 months' imprisonment, 3 years' probation, and ordered to pay $202,929 in restitution to VA in connection with her theft of VA

Dependency and Indemnity Compensation (DIC) benefits. The individual previously pled guilty to theft of Government funds and false statements. She fraudulently received benefits totaling over $200,000 from 1972 to 2002.

- A former VAMC agent cashier was sentenced to 5 years' probation and ordered to make restitution of $12,473 to VA. The sentencing stemmed from a joint investigation conducted by VA OIG and the Federal Bureau of Investigation (FBI), which disclosed the former VA employee, between 1999 and 2000, unlawfully received monies after submitting 462 false claims relating to beneficiary travel reimbursement.

Identity Fraud

- An individual was sentenced to 24 months' incarceration, 5 years' supervised release, and ordered to pay $50,000 in restitution after pleading guilty to charges relating to identity theft. The defendant admitted to using an actual veteran's name, Social Security number, and military service record to apply for medical benefits. Investigation revealed the defendant used the veteran's identity over the past decade in various fraudulent schemes. The defendant actually used the false identity to enlist in the U.S. Marine Corps, enroll in and receive care at a VA in-patient substance abuse program, and apply for public assistance benefits. The defendant also used false identity documents numerous times in the past while being processed for unrelated arrests.

- An individual was sentenced to 36 months' imprisonment, 3 years' probation, and ordered to pay restitution of $89,359 after he pled guilty to using a fake identity in the commission of a crime. An investigation substantiated that the individual, the half-brother of a veteran, used the veteran's identity to obtain credit and receive health care from two VAMCs.

Threats

- A veteran was indicted for making threats via interstate communications. The veteran had telephonically notified a state attorney general's office and a VARO veterans service representative of his intention to blow up that VARO. Both the VA OIG and FBI interviewed the veteran at his residence and confirmed that he was upset due to the denial of his service-connected benefits. The veteran was cautioned not to make any additional threats against VA or its employees. Approximately 1 hour after the interview, the veteran made a third bomb threat to a VA physician. Consequently, the VA OIG, FBI, and state police apprehended the veteran without incident.

Theft of Government Property

- A former VA employee entered into a pretrial diversion agreement wherein he agreed to make restitution to VA of $11,734 and to release his claim of ownership of photographic equipment valued at $2,752 and surrender it to VA. Federal prosecution was deferred for a period of 24 months. This agreement followed a joint investigation with VA police and disclosed that the former employee stole used VA-owned camera equipment originally valued at $58,500. The former employee traded the equipment for cash and/or new equipment at camera shops and at a trade show.

Procurement Fraud

- A contractor/vendor was indicted for conspiracy to make false claims and false statements involving 21 overt acts. These charges stem from the installation of automobile adaptive equipment into veterans' vehicles. Although used equipment had been installed in the vehicles, the investigation found that VA had been billed for new equipment. The investigation also disclosed the individual billed VA for equipment never

provided and unlawfully billed a 25 percent surcharge for certain vehicles. The VA loss is $92,380.

Credit Card Fraud

- Four individuals were arrested pursuant to state arrest warrants charging them with numerous counts of uttering[1] forged credit cards and organized fraud. In addition to the arrests, approximately 4,000 gallons of stolen fuel, three vehicles, and several stolen credit cards were confiscated. A joint investigation involving the VA OIG, General Services Administration (GSA) OIG, state police, and city police was initiated after the GSA OIG suspected that two GSA fuel credit cards assigned to vehicles leased to a VAMC were being used to fraudulently purchase large amounts of diesel fuel. The investigation revealed the suspects used electronic devices to surreptitiously copy the GSA credit cards as well as other credit cards. The suspects used the illegally copied credit cards to purchase diesel fuel from gas stations. They transported the fuel in trucks rigged with large liquid storage containers to remote dumpsites, where it was sold to dumpsite managers for well below market value. The dumpsite manager then sold the fuel, mainly to trucking companies for below-market value. The approximate value of the fraudulent charges was $12,500. Investigation is continuing, and additional arrests are anticipated.

- Five former VA employees were indicted after a grand jury returned a 125-count indictment charging each individual with false statements for their alleged role in a conspiracy to defraud VA. An investigation determined that each of the individuals used a Government-issued credit card to purchase items for their own personal use during a 3-year period from 2000 through 2002. The illegal purchases included a diamond ring, televisions, video and audio players, karaoke machines, clothing, and power tools. After making the purchases, the individuals submitted fraudulent purchase orders to VA in an effort to obscure the crime. The total loss to VA exceeds $45,000.

[1] **uttering** - a legal term meaning to put into circulation.

Veterans Benefits Administration

VBA provides wide-reaching benefits to veterans and their dependents, including compensation and pension 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 their homes, and educational benefits are obtained under false representations. The Office of Investigations spends considerable resources in investigating and arresting those who defraud operations of VBA.

Death Match Project

- The Office of Investigations is conducting an ongoing proactive project in coordination with VA OIG Information Technology and Data Analysis Division. The match is being conducted to identify individuals who may be defrauding VA by receiving VA benefits intended for veterans who have died. 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 8,700 possible investigative leads. Over 5,000 leads have been reviewed, resulting the development of 663 criminal and administrative cases. Investigations have resulted in the actual recovery of $9.2 million, with an additional $7.3 million in anticipated recoveries. The 5-year

projected cost avoidance to VA is estimated at $22.7 million. To date, there have been 79 arrests in these cases with several additional cases awaiting judicial actions.

Equity Skimming/Loan Guaranty Fraud

- Two individuals pled guilty to a Federal indictment charging that they engaged in an equity-skimming scheme between 1993 and 1999. The individuals, who owned and operated a real estate business, admitted fraudulently representing to homeowners in distress that they would take over the outstanding mortgage or tax payments, locate an outside investor to purchase the property, and contact the bank holding the mortgage. It is estimated that from 1996 to 1999, they collected over $980,000. Sentencing is pending. This scheme affected several homes with mortgages insured by HUD or guaranteed by VA. HUD has estimated a loss of $1.4 million. The total loss to VA is at least $70,000.

- An individual pled guilty to wire fraud and aiding and abetting after a joint VA OIG and HUD OIG investigation disclosed that two individuals perpetrated a multi-state scheme to take advantage of more than 1,000 homeowners whose mortgages were in default and facing foreclosure. Of this number, 178 properties were subject to mortgages guaranteed by the U.S. Government. The subjects contacted the distressed homeowners assuring them that they could "buy them some time" before foreclosure. The subjects then collected rent and fees from the homeowners but failed to make any payments on existing mortgages. As part of the scheme, they used fictitious names and Social Security numbers and filed more than 200 fraudulent bankruptcies to delay the foreclosure process. The subjects wrongfully collected $51,000 in rent and fees. The total loss to the Government was $390,000. Sentencing is pending.

Construction Fraud

- A former owner of a company was charged with offenses related to money laundering after the individual completed four transactions that transferred nearly $500,000 from the company's business account to his personal offshore account in 1998. The individual transferred these funds in order to conceal their existence in a scheme to defraud the business' bonding company. As a result of the charge, the individual faces possible forfeiture of his assets to the Government. This superseding indictment, the second in this investigation, adds to the previous charges leveled against the defendant, including false statements to the Small Business Administration and a commercial bank, and mail and wire fraud involving the business' bonding company and customers, including VA.

Fiduciary Fraud

- A man was arrested without incident pursuant to a felony arrest warrant after he was previously indicted on 65 counts of misappropriating funds entrusted to a fiduciary. The investigation determined the individual, a court-appointed fiduciary, committed fraud against his uncle, a VA beneficiary. Investigation disclosed that from 1998 to 2001, the individual misappropriated $54,621 in VA monetary benefits paid to him on behalf of his uncle.

- A woman was sentenced to 4 months' community service and 12 months' probation after she pled guilty to misappropriating funds with respect to her role as a fiduciary. The investigation disclosed the individual was the appointed financial guardian for a disabled veteran from 1997 to 2001. She diverted in excess of $60,000 of VA benefits for her own personal use, which included funding her own private business dealings.

Theft and Embezzlement

- A veteran and his wife pled guilty to charges of money laundering after an investigation determined that the veteran, who was receiving VA individual unemployability benefits, claimed that $25,000 in cash, discovered during execution of a search warrant, was earned performing mechanical work on cars. The veteran admitted he had failed to report this income to the Internal Revenue Service and VA. However, investigation determined that the cash was actually from a marijuana-growing operation run by the veteran, his wife, and his son. Investigation further revealed that the veteran, in the name of his unwitting nephew, fraudulently purchased the property, from which the majority of the marijuana plants were seized, so the veteran could avoid being linked to this location by law enforcement. This was a joint investigation between the VA OIG, Internal Revenue Service, and DEA.

Disability and Workers' Compensation Fraud

- An individual was arrested and charged with insurance fraud, perjury, and grand theft after a investigation determined that from 1994 to 2000, the individual filed false statements with VA and the Department of Labor, Office of Workers' Compensation Program in order to obtain workers' compensation benefits. The investigation revealed the individual fraudulently received benefits while owning and operating a counseling service that contracted with various state and local agencies. The individual unlawfully received workers' compensation benefits amounting to $424,511.

Theft of Benefits

- The daughter of a deceased VA beneficiary was sentenced to 5 months' imprisonment, 5 months' home confinement, and 2 years' supervised release, following her guilty plea to theft of Government funds. A joint VA OIG and Social Security Administration (SSA) OIG investigation disclosed the daughter concealed the death of her mother and, for more than 13 years, unlawfully cashed each of the benefit checks sent to her address. The daughter forged her mother's signature and cashed 165 checks that amounted to $73,328.

- The grandson of a deceased VA DIC benefits recipient was sentenced to 24 months' supervised release and ordered to pay restitution. The grandson previously pled guilty to an indictment charging him with theft of Government money. He continued to cash the benefit checks of his deceased grandmother until the award was terminated in 2002. In 1996, he completed a VA marital status questionnaire and mailed it back to VA to continue receiving the benefits. In 1997, he contacted VA, purporting to be the grandmother, and switched the payment method to direct deposit into a joint account with his deceased grandmother. The grandson confessed to converting the VA funds during an interview conducted by VA OIG special agents. This was a joint investigation with the U.S. Postal Inspection Service. The total loss to VA from 1992 to 2002 was $96,890.

- A veteran pled guilty to wire fraud and was sentenced to 18 months' imprisonment, 3 years' supervised release, and ordered to pay $146,570 in restitution. An investigation determined the veteran, who was receiving VA pension benefits, falsely reported he received no income while he was actually receiving monthly Social Security benefits.

- A veteran pled guilty to a criminal information[2] charging him with fraudulent acceptance of payments. He was sentenced to 5 months' imprisonment, 5 months' home confinement, and ordered to make restitution of $61,158 to VA. An investigation revealed the individual applied for

[2] **information** - a legal term for a formal accusation of a crime made by a public officer rather than by a grand jury indictment.

pension benefits and claimed to have no income or assets. However, he earned over $800 per month from interest and dividends from more than $200,000 in stocks that he owned. The individual claimed to be destitute and certified that he had no stocks, bonds, or cash. He had earlier received $280,000 from an insurance settlement.

- A veteran was arrested by VA OIG and SSA OIG agents on charges of theft of public money, false statements, and wire fraud. The veteran collected compensation benefits since 1991, claiming he could not walk without the use of braces, crutches, or a wheelchair. Because of the nature of the veteran's disability, he also received special monthly compensation, adaptive housing compensation, and assistance for the purchase of an automobile. Investigation disclosed that he could walk without the aid of the assistance devices. The veteran repeatedly performed physical acts that greatly exceeded claimed limitations. When seeking treatment at a VAMC, the veteran appeared to assume the role of a wheelchair-bound patient. Total loss to VA exceeds $400,000.

- The daughter of a DIC beneficiary was indicted for theft of Government funds after an investigation determined from 1988 to 2001, the individual used a bank card to withdraw her deceased mother's VA benefits. The loss to VA is $122,365.

- The girlfriend of a deceased veteran pled guilty to an information charging theft of Government funds after a VA OIG investigation revealed she concealed the veteran's death from VA and stole VA pension benefits totaling $100,349. The benefits included additional funds for aid and attendance that VA believed the girlfriend was providing. Sentencing is pending.

- The widow of a deceased veteran entered into a settlement agreement relative to a violation of the False Claims Act filed on behalf of VA. As part of this agreement, the widow wire-transferred $230,000 to the U.S. Treasury to settle the claim. An investigation initiated pursuant to the death match project revealed that the widow failed to report her husband's death to VA and negotiated his monthly compensation checks, which continued to be sent to his home address. Criminal charges were not pursued due to the widow's age. The $230,000 represents 153 percent of the $150,644 obtained by the widow after the veteran's death.

Fugitive Felon Program

The Office of Investigations has established a Fugitive Felon Program to identify VA benefits recipients who are fugitives from justice. The program evolved after Congress enacted Public Law 107-103, Veterans Education and Expansion Act of 2001, prohibiting veterans who are fugitive felons, or their dependents, from receiving specified benefits. The program consists of conducting computerized matches between fugitive felon files of law enforcement organizations and VA benefit system files. Once a veteran is identified as a fugitive, information on the individual is provided to the law enforcement organization responsible for serving the warrant to assist in the apprehension. Fugitive information is then provided to the Department so that benefits may be suspended and to initiate recovery action for overpayments. To date, the Fugitive Felon program has identified more than 12,000 matches leading to the arrest of 178 fugitive felons nationwide.

- An individual was arrested pursuant to a parole violation warrant issued by a state department of criminal justice. During the course of investigating possible pension fraud by the individual, VA OIG discovered he was on parole for burglary. VA OIG agents interviewed the individual and subsequently obtained a sworn statement in which he admitted to making false statements to VA. The individual's sworn

statement, in conjunction with a positive drug test from the state, resulted in the issuance of a parole violation warrant. The individual realized his parole was going to be revoked and became a fugitive. VA OIG coordinated with the state, including the sex offender's task force, to arrest the individual. The investigation of the individual's alleged pension fraud is ongoing.

- A state bureau of investigation requested assistance from the VA OIG in the capture of one of the state's 10 most wanted fugitives. The individual was wanted for allegedly committing murder. VA OIG agents determined the individual had been seeking medical treatment at a VA facility and immediately began checking records at the VAMC and the VARO. A VA file indicated the individual had several family members living nearby. Other records checked indicated the individual had been stopped by local police and had given his correct name; however, local police failed to run his name for outstanding warrants. The VA OIG was able to locate the individual within a week of receiving the request for assistance and coordinated with local and Federal counterparts to arrest the individual at the VAMC.

- VA OIG special agents and Deputy U.S. Marshals apprehended a veteran with an outstanding arrest warrant for murder. The veteran had been recently charged with intentionally causing the death of another by stabbing. The veteran was apprehended at a VA outpatient clinic.

- An individual was arrested based on address information provided by VA OIG to the FBI and a county sheriff's office. The county issued arrest warrants for the individual in November 1993 and April 1994 for dangerous drug offenses. In May 1995, the FBI obtained a Federal warrant and charged him with unlawful flight to avoid prosecution. In December 2002, the VA OIG forwarded an out-of-country address for the individual to the FBI and sheriff's office. It was obtained as a result of a match between the state wanted persons file and the VA C&P file that indicated the individual was currently receiving VA benefits. In January 2003, the FBI requested that VA not forward a due process letter to the individual, as they needed more time to coordinate the arrest with local authorities. The VA OIG was able to assist with this request, and local police subsequently took the individual into custody. He is currently awaiting extradition back to the United States.

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, analysis of photocopied documents, and suspected alterations of official documents.

There were a total of 17 completed laboratory cases during this semiannual period.

Laboratory Cases for the Period	
Requester	Cases Completed
OIG Office of Investigations	7
VA Top Management	4
VA Regional Offices	6
TOTAL	**17**

The following are examples of completed laboratory reports:

- An investigation of a veteran/VARO employee revealed that his compensation claim for the loss of the use of his left hand had been based on fraudulent statements and deceptive

demonstrations of his motor skills to VA doctors. The left hand was his dominant hand. During the criminal court trial, the forensic document analyst prepared court exhibits to show the jury the basis of his laboratory results, which determined the veteran distorted his natural handwriting. The jury found the veteran guilty of all criminal charges he had faced during the trial.

- The VA OIG investigated an individual who stole the name and Social Security number of another individual, which he used to purchase a foreclosed residence sold by VA. Laboratory handwriting examinations indicated the individual under investigation fraudulently authored signatures, entries on real estate documents, and Social Security documents. The forensic document analyst prepared court exhibits and planned to provide court testimony; however, the individual subsequently pled guilty.

- The VA OIG investigated the estranged wife of a veteran who, after his death, continued to cash the VA benefit checks issued to the veteran. The wife did not report the death of her husband and when confronted, denied she had cashed the checks. Laboratory examinations determined that the wife had forged the signature of the veteran. The forensic document analyst prepared court exhibits and planned to provide court testimony; however, the individual subsequently pled guilty.

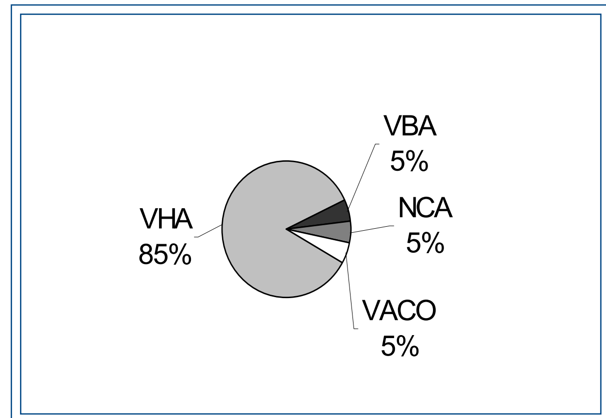
II. ADMINISTRATIVE INVESTIGATIONS DIVISION

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



Overall Performance

Output

- The Division closed 25 cases and issued 12 reports and 5 advisory memoranda.

Outcome

- VA managers agreed to take 25 administrative sanctions, including personnel actions against 15 officials, and corrective actions in 10 instances to improve operations and activities. The corrective actions included charging physicians annual leave for days they were absent from duty; issuing a chief of staff a bill of collection to recoup travel funds inappropriately paid to him; collecting fees due the Government from a contractor; directing a physician to repay the value of gifts he received from pharmaceutical companies; and revising erroneous guidance.

Samples of the Administrative Investigations Division reports issued during this period are provided below. These reports address serious issues of misconduct against high-ranking officials and other high-profile matters of interest.

Veterans Health Administration

Acceptance of Speaking Fees and Gifts

- An administrative investigation substantiated that a VAMC physician violated Federal ethics regulations when he accepted honoraria and a travel payment for speaking on matters related to his official duties, and accepted gifts of cash and travel payments from pharmaceutical companies, which were prohibited sources. VHA management officials agreed to take appropriate administrative action against the physician and require him to repay the dollar value of the gifts he improperly received.

Appearance of Not Acting Impartially

- An administrative investigation substantiated that a VAMC chief of staff violated Federal ethics regulations by signing his spouse's proficiency report as the approving official. The spouse received a within-grade increase immediately after the chief of staff signed the proficiency report, giving the appearance that he did not act impartially towards her. The chief of staff had been advised more than once to avoid participating in the spouse's supervisory chain, and knew he should not have signed the appraisal. VHA management agreed to take appropriate administrative action against the chief of staff.

Travel Voucher Irregularities

- An administrative investigation substantiated that, over a 2-year period, a VAMC chief of staff inappropriately claimed and was reimbursed for travel expenses incurred when he returned to a former duty station to provide weekend on-call services. The chief of staff knowingly claimed meals and incidental expenses for days he was not scheduled to be on-call. VHA management officials agreed to take appropriate administrative action against the chief of staff, and issue him a bill of collection for the funds inappropriately paid to him.

Physician Misuse of Official Time

- Administrative investigations substantiated that two full-time physicians misused their official time. In one case, a physician treated non-VA patients at the affiliated medical school, for compensation, during her VA tour of duty. In the second case, a physician scheduled appointments with her private practice patients during her VA tour of duty. Each physician was charged annual leave or issued a bill of collection for the days she was absent. VHA officials took appropriate administrative action against one physician; the other physician resigned.

Veterans Benefits Administration

Misuse of a Government Vehicle

- An administrative investigation substantiated that a VARO supervisor violated Federal law by willfully misusing a Government vehicle to transport him to work on a routine basis for 4 years. The supervisor acted with reckless disregard as to whether his use of the vehicle was authorized, and personally benefited from his actions in that, for 4 years, he did not incur expenses associated with normal home to work commuting. VBA officials agreed to take appropriate administrative action against the supervisor.

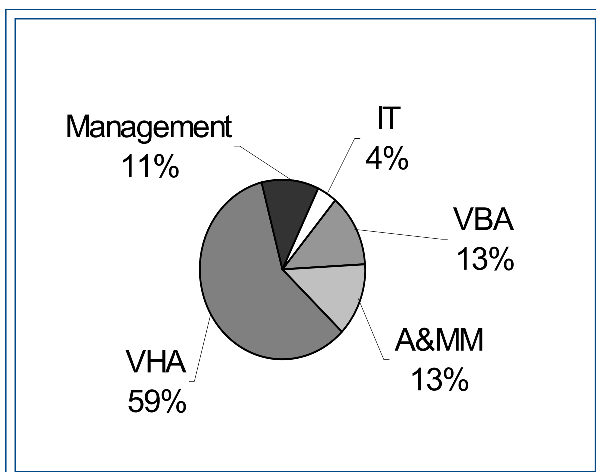
OFFICE OF AUDIT

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 a ceiling of 176 FTE allocated for its headquarters and 8 operating divisions located throughout the country. The following chart shows the allocation of resources used in auditing each of VA's major program areas.



In addition, the Office of Audit's Contract Review and Evaluation Division has 25 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 48 audits, evaluations, and reviews for an output efficiency of 1 report per 1.6 assigned FTE during this 6-month period. We also issued an additional 35 contract review reports, for an efficiency of 2.8 reports per assigned FTE for this 6-month period.

Outcome

- Recommendations to enhance operations and correct operating deficiencies have associated monetary benefits totaling approximately $4.4 million. In addition, contract reviews identified monetary benefits of $26.2 million associated with the results of preaward and postaward contract reviews.

Customer Satisfaction

- Customer satisfaction with independent financial and performance audits and evaluations during this reporting period was 4.2 on a scale of 5.0. The average customer satisfaction rating achieved for contract reviews was 4.7 out of a possible 5.0.

The following summarizes some of the audits completed during the reporting period organized by VA component: VHA, VBA, and Office of Management.

Veterans Health Administration

Quality of Care

Issue: Part-time physician time and attendance.
Conclusion: VHA's management controls were not effective in ensuring that part-time physicians met their employment obligations and that physician staffing was aligned properly with workload requirements.
Impact: Strengthened controls over time and attendance.

At the request of the Secretary of Veterans Affairs, we audited VHA's management of part-time physician time and attendance, physician productivity in meeting employment obligations, and physician staffing requirements. The audit objectives were to determine if: (i) timekeeping and other management controls were effective in ensuring that part-time physicians worked the hours required by their VA appointments; and (ii) VHA used effective procedures to align physician staffing with workload requirements.

VAMC managers did not ensure that part-time physicians met employment obligations required by their VA appointments. Although VHA had established time and attendance policy and procedures to account for part-time physicians, neither VHA headquarters officials nor VAMC managers enforced the policy. VHA management at many levels told us they were generally satisfied with physician productivity and believed VA received more value than it paid for from the services provided by part-time physicians, despite apparent timekeeping violations. Results of the audit clearly showed that part-time physicians were not working the hours established in their VA appointments; as a result, part-time physicians were not meeting their employment obligations to VA.

VHA does not have effective procedures to align physician-staffing levels with workload requirements. VAMCs did not perform any workload analysis to determine how many full-time employee equivalents were needed to accomplish the VAMCs' workload. In addition, VAMCs did not evaluate their hiring alternatives (such as part-time, full-time, intermittent, or fee basis). VAMC managers responsible for staffing decisions did not fully consider the physicians' other responsibilities - such as medical research, teaching, and administration - when they determined how many physicians the VAMCs needed. VHA officials told us the determination of the number of part-time physician employee equivalents needed has more to do with the financial needs of the affiliated university in meeting physician pay packages, than the number of hours needed by VA to meet patient workload requirements. In addition, only one of the managers at the five VAMCs we visited told their part-time physicians what was expected of them to meet their VA employment responsibilities. We believe communication of expectations and responsibilities would significantly improve operations at the VAMCs.

We recommended that the Under Secretary for Health take the following actions.

- Require that VISN and VAMC directors ensure part-time physicians meet their employment obligations and hold field managers accountable for compliance.

- Determine what reforms are needed to ensure VA physician timekeeping practices are effective in an academic medicine environment and VA physicians are paid only for time and service actually provided. Recommend statutory or regulatory changes needed to implement the reforms and publish appropriate policy and guidance.

- Establish performance monitors to measure VISN and VAMC enforcement of physician time and attendance; ensure desk audits are conducted

of timekeeping functions; provide continuing timekeeping education to supervisors, physicians, and timekeepers; require VAMC managers to certify compliance with applicable policies and procedures to VHA's Deputy Under Secretary for Operations and Management annually; and hold VHA managers accountable for successful implementation of time and attendance requirements.

- Apprise all part-time physicians of their responsibilities regarding VA timekeeping requirements.

- Evaluate appropriate technological solutions that will facilitate physician timekeeping.

- Develop comprehensive guidance for VAMCs to use when conducting desk audits.

- Establish appropriate training modules, making the best use of technological solutions for training VHA managers, VA physicians, and timekeepers in timekeeping requirements, responsibilities, and procedures.

- Publish policy and guidance that incorporates the use of workload analysis to determine the number of physicians needed to provide timely, cost effective, and quality service to veterans seeking care from VA.

- Require VAMCs to review their staffing structures (such as part-time, full-time, intermittent, or fee basis) and determine if these appointments are appropriate to the needs of the VAMC.

- Require that VISN and VAMC directors reassess staffing requirements annually and certify their staffing decisions to VHA's Deputy Under Secretary for Operations and Management.

- Evaluate alternative methods to acquire physician services and publish national guidance to assist VISN and VAMC directors in determining the best strategies for their regional, academic, and patient care circumstances.

- Publish guidance describing how VISN and VAMC managers should determine, monitor, and communicate the allocation of physician time among patient care, administrative duties, academic training, and medical research.

The Under Secretary for Health agreed with the findings and recommendations, except for: (i) the recommendation requiring the VAMC directors to perform an annual staffing assessment and provide a certification of their staffing decision; and (ii) the recommendation requiring national guidance on strategies to determine physician services. The Under Secretary provided an acceptable alternative implementation plan for the recommendation concerning the need for staffing assessments and certifications of the VAMC directors' staffing decisions. For the recommendation to require national guidance on strategies to determine physician services, the Under Secretary indicated guidance was currently available for acquiring physician services through a number of different means. However, the referenced current guidance does not assist VISN and VAMC directors in making the best choices in acquiring physician services. Since the Under Secretary indicated that staffing guidelines are under development, we will hold this recommendation open pending issuance of the staffing guidance and VHA's new policy on procuring clinical services under Section 8153 of Title 38, United States Code. We consider the Under Secretary's implementation plans to be acceptable. *(Audit of VHA's Part-Time Physician Time and Attendance, 02-01339-85, 4/23/03)*

Issue: Part-time physicians' time and attendance at VAMC Kansas City.
Conclusion: Two part-time physicians did not meet their responsibilities.
Impact: Strengthened controls over time and attendance.

At the request of the Secretary of Veterans Affairs, we reviewed an anonymous complaint sent to Congressman Ike Skelton alleging that two part-time physicians continue to abuse their time and attendance responsibilities by treating non-VA patients at the affiliated Kansas University Medical Center during their scheduled VA tours of duty. OIG investigators substantiated a previous accusation of time and attendance irregularities on the part of both physicians in October 2001.

We substantiated the allegation that both physicians did not meet their time and attendance responsibilities. In total, we estimate the physicians were overpaid $13,102. We found that the physicians treated non-VA patients at the affiliated Kansas University Medical Center during their scheduled VA time, in some cases working at the university while claiming sick leave or authorized absence from VA. The physicians were inappropriately paid for 76 hours ($5,393) when the physicians were at the university treating non-VA patients. We also found the surgery service timekeeper did not always use the subsidiary time and attendance report as the basis for paying the physicians. We identified a net total of 109 hours ($7,709) the physicians were paid in excess of the hours they claimed on their subsidiary time and attendance reports.

We recommended that the Director, VAMC Kansas City take the following actions.

- Issue bills of collection to the two physicians for the money paid them when they were working at the university and for the excess hours paid them due to timekeeper errors.

- Conduct a 100 percent review of surgery service timekeeping records to ensure physicians were paid for hours they worked.

- Remind all timekeepers that physicians should only be paid for the hours worked and that appropriate supporting documentation should be present before inputting time and attendance data into the official electronic time records.

The Director agreed with our findings and took immediate actions. Bills of collection were issued to both physicians on May 13, 2003 for the amounts shown in the report. A 100 percent review of the surgery service timekeeping records was conducted for the past 3 months. Directions were issued immediately to all timekeepers to re-emphasize the importance of accurate timekeeping. We consider the Director's implementation plans to be acceptable. *(Evaluation of Hotline Complaint Concerning Time and Attendance of Two Part-Time Physicians at Kansas City VAMC, 02-01198-103, 5/23/03)*

Issue: VHA's medical care waiting lists.
Conclusion: VHA can improve the accuracy of waiting lists.
Impact: Improved ability to assess and manage demand and credibility of VHA responses to internal and external stakeholder concerns.

The purpose of this audit was to verify the accuracy of the medical care waiting lists and determine the causes of any inaccuracies found. Results of audit showed that VHA's medical care waiting lists for new enrollees and established patients were overstated. Also, significant numbers of new enrollees were misclassified and should have been reported on the established patient waiting list. The inaccuracies occurred because appointment schedulers did not update the waiting lists as veterans received appointments or medical care, and they did not enter follow up appointments appropriately into the Veterans

Health Information Systems and Technology Architecture scheduling package. The total waiting list of 309,186 veterans should have been about 218,000 veterans, or 91,000 veterans (29 percent) fewer than reported.

It is important that the waiting list data be accurate because VHA uses the data in planning budget priorities, measuring performance, and determining whether strategic goals are met. Inaccurate waiting lists compromise the ability to assess and manage demand and credibility of VHA responses to internal and external stakeholder concerns. VHA managers recognized the need to improve the accuracy of tracking patients who were on waiting lists. In response, they began taking corrective action during our audit and plan to develop a nationwide electronic waiting list.

We recommended that the Under Secretary for Health take the following actions.

- Provide refresher training for staff using the scheduling package, to include the need to frequently update the waiting list and to enter follow up appointments correctly in the scheduling package. Also, provide direction to health care providers to specify in the electronic progress notes when they want the veterans to be scheduled for their next appointments.

- Update the FileMan routine so that it does not include erroneous appointments, duplicate names, or cancelled appointments on the waiting lists.

- Expedite implementation and monitor the accuracy of the electronic waiting list software.

The Under Secretary for Health agreed with the audit findings and provided acceptable implementation plans. *(Audit of VHA's Reported Medical Care Waiting Lists, 02-02129-95, 5/14/03)*

Veterans Benefits Administration

Loan Refunding Practices

Issue: Refunding decisions made by Loan Guaranty Service (LGS) regional loan center staff.
Conclusion: LGS needed to improve the quality of loan refunding practices and control of loan folders.
Impact: Better decision-making.

The purpose of the review was to identify the factors that may have contributed to the default and foreclosure of refunded loans. We focused on the refunding decisions made by LGS regional loan center staff for samples of loans that were seriously delinquent or pending foreclosure. We identified several issues that required management attention. LGS needed to implement clear and consistent loan refunding policies and procedures to improve the quality of loan refunding decisions. LGS also needed to develop and use performance measures and management reports to improve the monitoring of refunded loans. Additionally, LGS needed to identify and locate missing refunded loan folders. During our review, LGS management took steps, such as issuing a circular addressing quality assurance on refunded loans, which should improve loan refunding practices.

We recommended that the Under Secretary for Benefits ensure that LGS management takes the following actions.

- Monitors the implementation of Circular 26-02-7 to ensure loan servicing representatives verify each borrowers' income and credit history; document analysis of credit history and ability to make future loan payments; justify decisions to refund loans; and, in cases which appear questionable, obtain the concurrence of the loan administration officer.

- Develops and utilizes performance measures and management reports to effectively oversee and manage the loan refunding program and provide feedback to management.

- Identifies missing refunded loan folders and take steps to locate the folders, or reconstruct the folders.

The Under Secretary for Benefits agreed with the findings and provided details on corrective actions taken to address the recommendations. *(Review of VBA Loan Guaranty Service Loan Refunding Practices, 00-02021-86, 4/25/03)*

Office of Management

VA's Consolidated Financial Statements

Issue: Financial management.
Conclusion: Management letters were issued to assist VA in improving financial management.
Impact: Improved financial reporting and controls.

The independent public accounting firm, Deloitte & Touche LLP, performed the audit of VA's Consolidated Financial Statements (CFS) under contract to the OIG. As part of the audit, we issued eight 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 (report number 02-01638-152): (i) reiterates two material weaknesses and five reportable conditions identified in the previously issued CFS audit report number 02-01638-47 (Audit of the Department of Veterans Affairs CFS for FYs 2002 and 2001, 1/22/03); (ii) provides 20 additional observations and recommendations from the audit to further assist the Department in improving internal control and financial reporting; and (iii) reports the results of follow-up of prior year CFS audit findings. The other seven management letters related to management of three VA data centers and four application systems.
[(i) Management Letter, Audit of VA's FYs 2002 and 2001 CFS General Systems Control Review at the Austin Automation Center, 02-01638-118, 7/17/03;
(ii) Management Letter, Audit of VA's FYs 2002 and 2001 CFS General Systems Control Review at the Philadelphia Information Technology Center, 02-01638-119, 7/17/03;
(iii) Management Letter, Audit of VA's FYs 2002 and 2001 CFS General Systems Control Review at the Hines Benefit Delivery Center, 01-01638-120, 7/17/03;
(iv) Management Letter, Audit of VA's CFS for the FY Ended September 30, 2002, 01-01638-146, 8/6/03;
(v) Management Letter, Audit of VA's FYs 2002 and 2001 CFS Compensation and Pension Review, 02-01638-151, 8/11/03;
(vi) Management Letter, Audit of VA's FYs 2002 and 2001 CFS Financial Management System Review, 02-01638-152, 8/11/03;
(vii) Management Letter, Audit of VA's FYs 2002 and 2001 CFS Loan Guaranty Systems Follow-up Review, 02-01638-153, 8/11/03; and
(viii) Management Letter, Audit of VA's FYs 2002 and 2001 CFS Personnel and Accounting Integrated Data System Review, 02-01638-154, 8/11/03]

Preaward Contract Reviews

Issue: Federal Supply Schedule (FSS) vendors' best prices.
Conclusion: Vendors can offer better prices to VA.
Impact: Potential better use of $13.8 million.

Preaward reviews of 9 FSS and direct delivery offers made recommendations for potential better use of $13.8 million. Recommendations to negotiate lower contract prices were made because the manufacturers were not offering the most favored customer prices to FSS customers when those same prices were extended to commercial customers purchasing under similar terms and conditions as the FSS.

Issue: Health care resource contracts.
Conclusion: VA can negotiate reduced contract costs.
Impact: Potential better use of $3.8 million.

We completed reviews of 12 proposals from VA affiliated medical schools involving the acquisition of scarce medical specialists' services. We concluded that the contracting officers should negotiate reductions of $3.8 million to the proposed contract costs because of differences between the proposed costs for the services solicited and the costs the affiliate could justify.

Postaward Contract Reviews

Issue: Contractor overcharges for pharmaceuticals and medical supplies.
Conclusion: Overcharges were disclosed.
Impact: Recovery of more than $8.5 million.

We completed 11 reviews of vendors' contractual compliance with the specific pricing provisions of their FSS contracts. The reviews resulted in recoveries amounting to $8.4 million. We also completed 3 drug pricing Public Law 102-585 compliance reviews at pharmaceutical vendors, with recoveries of $162,000.

OIG efforts to maintain an aggressive postaward contract review program resulted in numerous voluntary disclosures and refund offers from companies relating to overcharges on their contracts with VA. Postaward contract reviews are a major source of recoveries to VA's Revolving Supply Fund. These recoveries are a result of VA's work as a team, with the Office of Acquisition and Materiel Management, Office of General Counsel, and VHA, to ensure that VA's contracts are fairly priced.

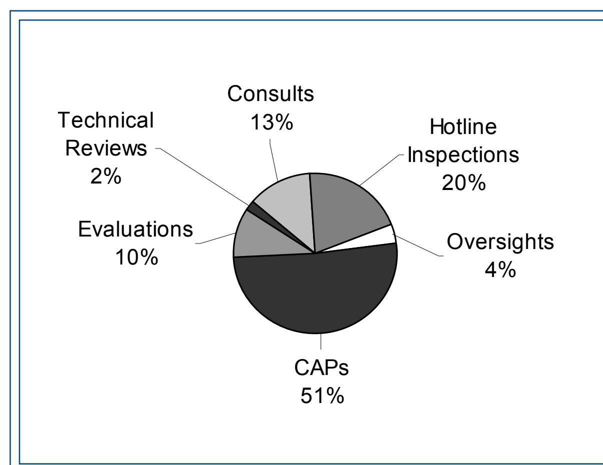
OFFICE OF HEALTHCARE INSPECTIONS

Mission Statement

Promote the principles of continuous quality improvement and 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 46 FTE allocated to staff headquarters and field operations. The following chart shows the allocation of resources utilized to conduct evaluations, inspections, CAP reviews, oversight, technical reviews, and clinical consultations in support of criminal investigation cases.



Overall Performance

Output

- Participated in 23 CAP reviews to evaluate health care issues and made 58 recommendations and 49 suggestions that will improve operations and activities, and the care and services provided to patients.

- Completed one summary evaluation report and made six recommendations to improve the operations and effectiveness of VHA quality management (QM) programs and patient care and safety in VHA health care facilities.

- Completed 17 Hotline cases, which consisted of reviews of 55 issues. We issued reports on eight of the cases and administratively closed the remaining nine cases. We made 21 recommendations that will improve the health care and services provided to patients.

- Completed one interagency report. The Offices of Inspectors General of the Departments of Agriculture, Defense, Energy, Health and Human Services, and VA formed a committee to ensure coordination of efforts to address security controls over biological agents.

- Provided clinical consultative support to investigators on 13 criminal cases.

- We oversaw the work of VHA's Office of the Medical Inspector on four projects.

Outcome

- Overall, OHI made or monitored the implementation of 85 recommendations and 49 suggestions to improve the quality of care and services provided to patients and their families. VHA managers agreed with all our recommendations and provided acceptable implementation plans. VHA implementation actions will improve clinical care delivery, management efficiency, and patient safety, and will hold employees accountable for their actions.

Customer satisfaction

- Survey results showed an average rating of 4.3 out of a possible 5.0.

Veterans Health Administration

Summary Evaluations

Issue: VHA quality management programs.
Conclusion: Actions were needed to strengthen programs in VHA facilities.
Impact: Improved monitoring and follow up on quality of care and services.

The purposes of this review were to determine whether: (i) VHA facilities had effective, comprehensive QM programs designed to monitor patient care activities and coordinate improvement efforts; (ii) VHA facility senior managers supported QM efforts; and (iii) VISN directors provided support in data management.

Our review showed that facility QM plans were current but did not always include all significant patient care areas or all programs that had mandated QM reporting requirements. We found some sophisticated data analyses, but facility managers did not consistently analyze data collected for all monitors or benchmark their results. Some significant QM actions failed because existing tracking systems did not sufficiently assure successful implementation of recommended QM actions. Facility managers need to ensure that recommended actions are fully implemented and evaluated. Clinical managers did not always consider QM results in their biennial reprivileging decisions. While senior facility managers voiced strong support for QM efforts, they stated that VISN and other national demands reduced their ability to routinely visit patient care areas. Only about half of the employees who responded to our survey said that senior managers had made rounds in their areas. Senior managers need to maintain a visible presence in patient care areas. Many facilities had not established acceptable methods for analyzing mortality data.

We made several recommendations. The Under Secretary for Health concurred and provided responsive implementation plans. *(Healthcare Inspection, Evaluation of Quality Management in VHA Facilities, 02-00026-106, 6/4/03)*

Issue: Interagency summary report on security controls over biological agents.
Conclusion: Agencies need to strengthen controls over agents.
Impact: Enhanced safety for veterans, employees, and the general public.

After a series of Bacillus anthracis (anthrax) mailings following the September 11, 2001, terrorist attacks, the concern that terrorists or extremist groups might use nuclear, biological, or chemical agents as weapons of mass destruction against civilians within the United States made the need to protect those agents a high priority. Congress and various Federal agencies have undertaken numerous initiatives over the past year to improve the Nation's ability to combat terrorism and minimize the threat of weapons of mass destruction, specifically biological agents.

To address security controls over biological agents subsequent to the anthrax mailings, the Offices of the Inspectors General of the Departments of Agriculture, Defense, Energy, Health and Human Services, and VA formed an interagency committee to ensure close coordination of audits, evaluations, and inspections. This interagency report summarizes issues identified in 26 reports published by the five committee-member agencies and one report published by the Army Inspector General from February 2, 2001, through April 16, 2003. The VA OIG published one of these 27 reports. Of the 27 reports, 26 addressed one or more of the following 9 systemic issues. The issues concerned the need to strengthen physical security, personnel access controls, inventory accountability, emergency disaster plans, registration with the Centers for Disease Control and Prevention, import and export of agents,

training, management oversight, and policies and procedures.

Senior officials at each agency have taken actions to improve security controls over biological agents in response to the published reports, but more needs to be done. Agencies need to diligently continue to address problem areas identified in this report. *(Interagency Summary Report on Security Controls Over Biological Agents, D-2003-126, 8/27/03)*

Healthcare Inspections

Issue: Substandard care and patient abuse.
Conclusion: The facility's policy for reporting incidents of possible verbal abuse needed strengthening.
Impact: Improved patient safety.

We initiated an inspection of allegations that a patient received substandard care, his personal belongings were stolen or misplaced, and he was verbally abused. The purpose of the inspection was to determine the validity of the allegations. Our interviews with the patient and the clinical staff, and our review of the patient's medical records, led us to conclude that the patient received good care.

The complainant told us that employees stole or misplaced some articles of the patient's clothes, mostly T-shirts. We were unable to determine if any clothing was missing; however, according to the complainant and the nurse manager, no personal belongings have been lost since the initial allegation. Family members are now being asked to write the name of the patient on all clothing, as it was believed the items in question may have been lost in the wash.

We interviewed patients as well as nursing employees, nurse managers, and physicians regarding the complainant's allegations of abuse. We also reviewed incident reports for the preceding 12 months. The complainant informed us she reported the incident of a nurse's verbal abuse of the patient on September 22, 2002. We could find no record of the incident. The nurse named in the allegation could not recall the incident. She denied the allegation and asserted she provides good care to patients. We interviewed all the nursing staff on duty the day of the alleged incident and none could recall the events as described by the complainant. We found a social worker who received a call from the complainant on the day in question. He concluded from the complainant's description of the events that the patient was not subjected to verbal abuse. Although we could not completely confirm or refute the incident, we found it should have been reported by the social worker and investigated by VAMC management. We concluded that incident reporting requirements needed strengthening and clinical managers needed to better communicate with the complainant to address her concerns. We made two recommendations. The VISN Director and VAMC Director agreed and provided acceptable implementation plans. *(Healthcare Inspection, Patient Care Issues, VAMC Washington, DC, 03-03412-165, 8/21/03)*

Washington VA Medical Center
Washington, D.C

Issue: Substandard care and quality management issues.
Conclusion: Clinicians did not comport with standards of care for three patients.
Impact: Improved quality of care and patient safety.

We reviewed allegations of substandard care and other health-related issues. The purpose of the inspection was to determine whether the allegations, made primarily by a staff psychiatrist, had merit. This review was an extension of an earlier OIG review titled "Patient Care Issues, VA Hudson Valley Health Care System, Franklin Delano Roosevelt Campus, Montrose, NY," report number 02-02374-08, 10/18/02.

In this most recent report, we discussed 13 cases brought to our attention and found lapses in psychiatric care in 3 cases. Before our inspection, clinical managers had reviewed the issues and circumstances of concern and recommended corrective actions pertaining to each case in which care was deficient. Based on actions taken, we made no further recommendations.

We also reviewed allegations concerning statements made to the media and given wide coverage in a June 9, 2002, newspaper article. The article quoted a Franklin Delano Roosevelt Campus psychiatrist as saying that the "...magnitude of neglect [of VA Hudson Valley Health Care System patients] is horrendous." The psychiatrist told us that the newspaper reporter took his comments out of context and that he did not mean to imply that clinicians provided negligent patient care.

We reviewed allegations that clinicians released patients without adequate discharge planning. We confirmed one such case in our October 2002 inspection. To prevent similar incidents from occurring, clinicians revised their discharge planning process. They also formed a permanent committee to provide oversight and consultation to clinicians involved in discharge planning.

Hudson Valley Healthcare System
Montrose, NY

The psychiatrist, who was first quoted in the June 2002 newspaper article regarding falsification of medical records, told us he had no knowledge that anyone altered or inappropriately changed records. We did not substantiate the allegation that the peer review process was flawed. Similarly, we did not substantiate allegations that there were no systematic procedures to review the quality of patient care, verify credentials, and privilege physicians. We found that managers had held numerous discussions with the psychiatrist and had listened to his many concerns. *(Healthcare Inspection, Patient Care and Quality Management Issues, Hudson Valley Healthcare System, Montrose, New York, 02-02374-126, 7/21/03)*

Issue: Suspicious deaths.
Conclusion: Policy for defining room assignments is needed. Clinicians need to conduct quality reviews, and analyze and trend all serious patient incidents.
Impact: Improved patient safety.

We initiated an inspection in response to allegations concerning a patient-on-patient assault, patient neglect, broken nurse call lights, and

problems with implementing the bar code medication administration system. We confirmed that there was a patient-on-patient assault, but there was no evidence to show that the assault contributed to the patient's death. The patient suffered musculo-skeletal pain in his trunk and right hip. A few weeks later, the patient developed a respiratory infection. The patient's condition deteriorated rapidly and he died. Physicians concluded, and the chart review supported the conclusion, that the cause of death was pneumonia secondary to the patient's post-fall sedentary lifestyle.

We also found that the VA medical facility did not: (i) have a written policy defining the criteria for making patient room assignments; (ii) forward incidents for review by the violent behavior prevention program committee; or (iii) transfer patients to facilities better equipped to manage aggressive behaviors. Managers had not conducted a root-cause analysis of the assault, which might have provided further information. Also, managers were not trending assaults and did not activate the alert function in the electronic medical record that identifies patients with histories of aggressive behaviors.

We did not confirm that a patient died because he did not receive respiratory treatments. We did not substantiate an allegation that a broken nurse call light contributed to another patient's death, but we did find operational problems with broken nurse call lights and pillow speakers. We also concluded that while there were problems during implementation of the facility's bar code medication administration system, we could find no evidence of serious injuries or patient deaths associated with these problems. We further concluded that problems related to software incompatibility continue to occur and need to be addressed.

VA North Texas Health Care System
Bonham, TX

We made six recommendations. The VISN Director concurred with the recommendations and provided acceptable implementation plans. *(Healthcare Inspection, Alleged Suspicious Deaths, VA North Texas Health Care System, Bonham, Texas, 02-02863-107, 6/4/03)*

Issue: Sanitation, pest problems, and security.
Conclusion: Pest control program and general maintenance needed strengthening, and patient information and physical security needed improvement.
Impact: Improved patient safety.

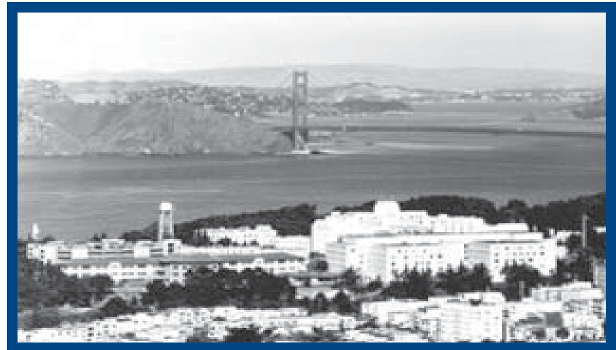
We conducted this inspection in response to allegations of rodent and insect infestations and unsanitary conditions. An anonymous complainant alleged that the VA Chicago Health Care System, West Side Division, was filthy and was infested with rodents, fruit flies, and garbage. He specifically cited the first floor bathrooms as being dirty, malodorous, and in need of repair. The complainant further alleged that managers allowed a veterans group called Veterans Strike Force One to maintain a display table in the main lobby and that members of this group disrupted the patient care environment by playing loud music, eating, and sleeping in the lobby.

We concluded that rodent control was an ongoing endeavor, but the facility was not infested with rodents or insects. Managers established a pest control program that appeared generally effective and addressed concerns as they were identified. Trash removal was generally adequate, but the contractor needed to increase the frequency of emptying building trash receptacles. We found that first floor bathrooms required more frequent cleaning and improved maintenance and some patient care areas required additional cleaning, but we concluded that unsanitary conditions were not a pervasive problem throughout the facility. We further found that confidential patient information security and medication security needed improvement on two inpatient wards and that managers needed to increase efforts to strengthen security by prohibiting individuals who do not have business with VA from entering the facility. We found that Veterans Strike Force One members were present in the lobby and other high traffic areas; however, they did not disrupt patient care.

We made five recommendations. The VISN Director agreed with the findings and recommendations and provided acceptable implementation plans. *(Healthcare Inspection, Environment of Care Issues, VA Chicago Health Care System, Chicago, Illinois, 02-03297-99, 5/23/03)*

Issue: Inappropriate care and unethical conduct.
Conclusion: There was no evidence of inappropriate care.
Impact: Substantiated appropriate treatment.

We conducted an oversight inspection of review activities, primarily initiated and performed at the direction of VISN 21. We conducted this inspection to determine if allegations concerning enrollment into a human immunodeficiency virus (HIV) investigational drug study, clinical care, and alleged unethical conduct by clinicians at VAMC San Francisco were successfully addressed at the VISN level. The complainant, a patient with acquired immune deficiency syndrome (AIDS), alleged that in order for him to be eligible for enrollment in investigational AIDS drug studies, he was required to take AIDS drugs that were known to be toxic. The complainant stated he initiated the drug regimen and that it resulted in a severe side effect. He alleged that he was not placed in the research protocol as promised.



San Francisco VA Medical Center
San Francisco, CA

We did not substantiate the allegations that VAMC clinicians promised the complainant enrollment into an investigational protocol, that they implicitly coerced him into taking harmful drugs, or that they inappropriately denied him access to investigational studies. We found that VAMC clinicians considered the complainant for two investigational protocols but the complainant did not meet the criteria for either study. We did not substantiate the allegation of poor clinical care. We concurred with the VISN reviewers that the drug regimen prescribed by the VAMC's physicians was the best one for his HIV disease at that point in time. We found that, while clinician communications could have been more sensitive to the complainant, VAMC employees did not treat the complainant in an unethical manner. We concluded that the review, performed at the request of the VISN 21 Director, was thorough and detailed. It was independent, and was performed by a group external to VISN 21. It was consistent in all regards with our own review. It defined and

addressed the issues raised by the complainant. Therefore, we did not make any recommendations. *(Healthcare Inspection, Patient Care Issues, VAMC San Francisco, California, 03-01986-180, 9/30/03)*

Issue: Substandard care and patient abuse.
Conclusion: There was no evidence of substandard medical care or patient abuse.
Impact: Substantiated quality of care and patient safety.

We initiated an inspection of a complainant's allegations that the Dental and Oral Surgery Clinic provided substandard care and subjected patients to abuse. We did not substantiate the allegations. The complainant's description of events was not supported by the patients' medical records and associated documents or by patients' and employees' testimony. Clinicians were appropriately credentialed and privileged and followed established policies and procedures. Patients were properly monitored during conscious sedation procedures, and we found evidence of adequate staffing and monitoring during procedures. The QM coordinator denied that there were any issues regarding the quality of anesthesia or dental care, and our inspection confirmed this statement. The patients' medical records showed that physicians discussed specific treatments and potential complications with patients. Patients agreed to procedures and provided consent forms. In the cases reviewed, dental/oral surgery was clinically indicated and improved the patients' quality of life. We concluded there was no evidence of substandard patient care or abuse in the Clinic. Therefore, we did not make any recommendations. *(Healthcare Inspection, Alleged Substandard Care and Patient Abuse, VA North Texas Health Care System, Dallas, Texas, 03-00607-147, 8/11/03)*

Issue: Inappropriate medical care.
Conclusion: The patient received appropriate medical care.
Impact: Substantiated quality care and patient safety.

We received allegations of inappropriate medical care at the VA Southern Nevada Healthcare System, Las Vegas, Nevada. The purpose of this inspection was to determine the validity of allegations that VA clinicians did not provide appropriate medical care to the complainant's husband and did not forward his medical information when he was transferred to a private hospital. We interviewed the complainant and clinicians involved in the patient's care. We reviewed the medical records, relevant facility policies, and VA's previous response to the complainant. We did not substantiate the allegations. Therefore, we made no recommendations. *(Healthcare Inspection, Quality of Care Issues, VA Southern Nevada Healthcare System, Las Vegas, Nevada, 03-02153-166, 8/21/03)*

VA Southern Nevada Healthcare System
Las Vegas, NV

Issue: Sanitation and pest problems.
Conclusion: Pest control measures were generally effective.
Impact: Improved sanitation and environment of care.

We initiated an inspection in response to allegations that the VAMC had recurring pest problems. We substantiated the allegation that pest control issues continually challenge VAMC managers and concluded that certain actions could strengthen their environmental management program. We also substantiated that feral cats, wild skunks, and other wild life on the Jefferson Barracks Division grounds routinely required management attention. Employees did not always cover dumpsters that contained food waste and garbage. We did not find evidence of bird feces on the floors, walls, and eaves of the rear loading docks as alleged; however, we found bird nests and feces in the rafters of a patio outside one of the buildings. In addition, we identified conditions that were not included in the allegations but were serious enough to require corrective actions.

We made eight recommendations to improve environmental management program operations and other concerns. The Acting VISN Director provided comments and implementation plans that met the intent of our recommendations. *(Environment of Care Issues, VAMC St. Louis, Missouri, 02-02868-105, 6/4/03)*

Healthcare Inspections Consultations

During the reporting period, OHI inspectors provided consultation to the Office of Investigations staff on 13 criminal investigation cases. Nine of the cases required intensive medical record reviews and interviews with witnesses.

OFFICE OF MANAGEMENT AND 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 responsible for a wide range of administrative and operational support functions. The Office includes five divisions.

I. Hotline – The Division determines action to be taken on allegations received by the OIG Hotline. The Division receives thousands of contacts annually from veterans, VA employees, and Congress. The work includes controlling and referring many cases to the OIG Offices of Investigation, Audit, and Healthcare Inspections, or to impartial VA components for review.

II. Operational Support – The Division performs follow up on implementation of OIG report recommendations; Freedom of Information Act/ Privacy Act (FOIA/PA) releases; strategic, operational, and performance planning; and OIG reporting requirements and policy development.

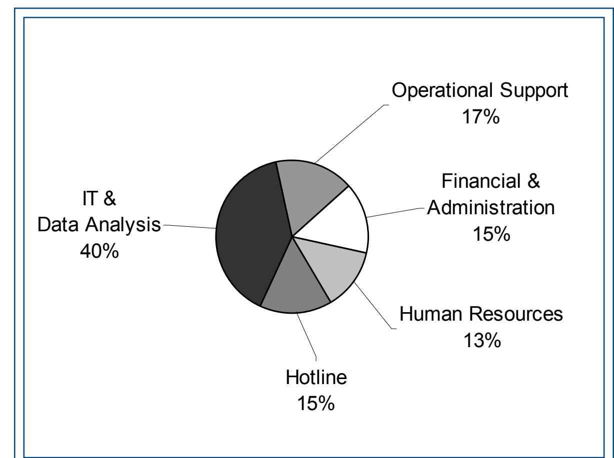
III. Information Technology (IT) and Data Analysis – The Division manages nationwide IT support, systems development and integration; represents the OIG on numerous intra- and inter-agency IT organizations; and does strategic IT planning for all OIG requirements. The Division maintains the Master Case 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. Financial and Administrative Support – The Division is responsible for OIG financial operations, including budget formulation and execution, and all other OIG administrative support services.

V. Human Resources Management – The Division provides the full range of personnel management services, including classification, staffing, employee relations, training, and incentive awards program.

Resources

The Office of Management and Administration has 57 FTE allocated to the following areas.



I. HOTLINE DIVISION

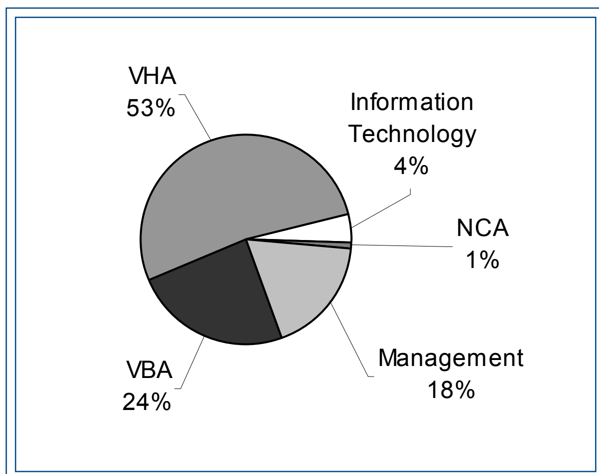
Mission Statement

Ensure that allegations of criminal activity, waste, abuse, and mismanagement are responded to in an efficient and effective manner.

The Division operates a toll-free telephone service, Monday through Friday, from 8:30 a.m. to 4 p.m. Eastern time. Employees, veterans, the general public, Congress, U.S. General Accounting Office, and other Federal agencies report issues of criminal activity, waste, and abuse through calls, letters, faxes, and e-mail messages. The Hotline Division carefully considers all complaints and allegations; OIG or other Departmental staff address mission-related issues.

Resources

The Hotline Division has eight FTE. The following chart shows the estimated percentage of resources devoted to various program areas.



Overall Performance

During the reporting period, the Hotline received 7,194 contacts, which resulted in opening 570 cases. The OIG reviewed 190 (33 percent) of these and referred the remaining 380 cases to VA program offices for review.

Output

- During the reporting period, Hotline staff closed 650 cases, of which 219 (33 percent) contained substantiated allegations. We wrote 127 letters responding to inquiries received from Members of the Senate and House of Representatives.

Outcome

- VA managers imposed 75 administrative sanctions against employees and took 128 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled almost $1.4 million.

Veterans Health Administration

Quality of Patient Care

The responses to Hotline inquiries by VA management officials indicated that 48 allegations regarding deficiencies in the quality of patient care provided by individual facilities were found to have merit and required corrective action. Examples of the issues follow.

- A VHA review revealed poor, abusive, and neglectful care of a patient in a nursing care unit. This was based on a complaint lodged by the patient's daughter, who reported staff had verbally abused the patient, left him unattended while incontinent for long periods of time, positioned his food tray out of his reach, and failed to help him back into bed in a timely manner. During his stay, the patient developed a contact ulcer (bedsore) and

lost over 30 pounds. The review of the patient's records acknowledged the contact ulcer and indicated the facility's skin care program is being reevaluated to prevent future occurrences. Management established a policy requiring all patients to be weighed on admission, discharge, and monthly during their stay. Furthermore, management implemented a range of procedural changes to improve patient care, staff courtesy and communications, and staff supervision.

- A VHA review determined that a program assistant should not be responsible for making clinical decisions as to which patients to reschedule. Management regrets that the employee was placed in this untenable position. The process has been completely revamped and clinicians will make these decisions in the future.

- A VHA review found that the VAMC failed to coordinate a veteran's care after his primary care physician retired and he was not informed of any future clinic visits. As a result, several appointments have been scheduled for the veteran.

Employee Misconduct

The responses to Hotline inquiries by management officials indicated that 15 allegations of employee misconduct at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow.

- A VHA review substantiated the allegation that a VAMC supervisor had an affair with one of his employees and engaged in sexual acts during duty hours at the facility. A letter of removal was issued to the supervisor; however, based on the supervisor's 16 years of service, management decided a 10-day suspension would be appropriate. The other employee involved received a letter of counseling.

- A VHA review substantiated the allegation that an employee misused Government equipment to download sexual photos from the internet. The employee was issued a 30-day suspension and signed a settlement agreement that could result in removal if the employee does not abide by the conditions of the agreement over the next year.

- A VHA review substantiated the allegation that a supervisor used his Government e-mail account to forward pornographic materials to his subordinates. Management suspended the supervisor for 5 days.

- A VHA review determined that an employee engaged in an amorous relationship with a patient, in violation of VAMC ethics standards. The review also determined that the employee engaged in an improper financial transaction with the patient.

Time and Attendance

The responses to Hotline inquiries by management officials indicate that 11 allegations of time and attendance abuse at individual VA facilities were found to have merit and required corrective action. An example follows.

- A VHA review found that compensatory time was annotated on time sheets, but was not posted on time cards. As a result, two employees will be counseled regarding ensuring that compensatory time previously approved is officially requested, posted, and treated in the same manner as annual and sick leave.

Fiscal Controls

The responses to Hotline inquiries by management officials indicate that nine allegations of deficient or improper fiscal controls at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow.

- A VHA review determined that a private medical facility billed a civilian health and medical

program of a VA subscriber for services she had not received. The facility corrected its records and refunded $825 to the subscriber.

- A VHA review confirmed that a patient filed for bankruptcy and was approved to have his debts discharged. However, the VAMC failed to update his records, thus causing his account to be offset for $103. The patient's records were updated and all debts cancelled. Additionally, he was refunded the total offset.

Patient Safety

The responses to Hotline inquiries by management officials indicate that nine allegations of patient safety deficiencies at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow.

- A VHA review substantiated the allegation that a VAMC failed to follow VA policy and code requirements in biological testing for a 7-month period and failed to have a certified water distribution operator on site. Management has taken corrective action to reestablish the contract to provide monthly testing. Appropriate disciplinary action will be taken against the managers responsible for the program element. An application was submitted to the state for certification as a water distribution operator.

- A VHA review found that oxygen tanks were being delivered to a veteran half full. The tanks were being bumped in transit, causing the gas to slowly leak from the tanks. As a result, the company responsible for the delivery of the tanks will perform periodic checks to ensure the tanks are properly filled. A log of serial numbers will be maintained and monitored to detect any pattern of problems with individual tanks.

- A VHA review determined an ongoing concern with missed communication, lack of specific infection control information about patients with resistant organisms, and various isolation precaution procedures. The elimination of paper charts and changes in isolation equipment took away the visual cues that were relied upon in the past to communicate this information. An interdisciplinary analysis team was launched to design methodologies for intra-facility communication of patient-specific infection control information.

- A VHA review confirmed that a veteran received overlapping controlled substance prescriptions from two different VAMCs. The veteran's pharmacy profile has been flagged, and his clinical providers have addressed this issue in the patient's medical treatment plan.

Government Equipment and Supplies

The responses to Hotline inquiries by management officials indicate that seven allegations involving misuse of Government equipment and supplies at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow.

- A VHA review confirmed that a supervisor sent inappropriate and offensive e-mails on the VA computer system to her staff. The employee received a written counseling and apologized for her poor judgment.

- A VHA review determined that a supervisor made various unauthorized and lengthy calls on his telephone extension. Telephone records showed 113 calls originated from his extension during various times of the day, with one call lasting 114 minutes. The supervisor was given a verbal counseling.

- A VHA review revealed that a union representative/nurse misused her Government-issued credit card to purchase an airline ticket and other personal items. As a result, her credit card was cancelled and appropriate personnel actions will be taken.

Contracting Activity

The responses to Hotline inquiries by management officials indicate that three allegations involving contracting improprieties or problems with contracted services at individual VA facilities were found to have merit and required corrective action. An example follows.

- VHA reviewed a complaint that veterans were removed from a contracted community residential care facility. It was determined that patients were appropriately removed because of various safety violations. Management had temporarily relocated the veterans to the VAMC domiciliary, pending appropriate community placement.

Identity Issues

The responses to Hotline inquiries by management officials indicate that nine allegations involving identity issues at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow.

- A VHA review determined that a veteran's brother used the veteran's identity and VA information to qualify for health benefits and subsequently received medical care totaling $2,286. The VAMC's health benefits section has been reminded of the importance of verifying the identity of new veterans, when possible, or if there are any underlying suspicions as to his/her eligibility status. The VAMC health administration service has been actively reviewing this issue, and the VACO staff will provide guidance.

- A VHA review concluded that a physician failed to correctly identify a patient under his care; thereby prescribing medication that, in fact, was for another of his patients. The patient recognized the medication error while still in the ambulatory care area and brought it to the attention of the administrative officer on duty. Also, a nurse failed to follow the established process for dispensing of medications from the automated medication cabinet by not matching the medications prescribed against the profile of the respective patient. The nurse manager reviewed the process for identification for dispensing of medication from the automated medication cabinet with the nurse. Action plans were developed to appropriately address these issues. Additionally, the processes and policies on how to correctly identify a patient and how to correctly dispense medication using the automated medication cabinet will be reviewed with the physician and nursing staff every 6 months.

Privacy Issues/Health Insurance Portability and Accountability Act (HIPAA)

The responses to Hotline inquiries by management officials indicate that 10 allegations involving violations of privacy and the new HIPAA by employees at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow.

- A VAMC review found lapses in compliance with provisions of the Privacy Act and HIPAA by VAMC staff. A veteran had reported that while he was being discharged, the staff had simply cut off his patient identification bracelet, which contained sensitive personal and medical information, and discarded it intact into a nearby trash can. The director issued guidance on the proper handling of these bracelets.

- A VHA review found that a supervisor discussed an employee's personal medical information with other co-workers. As a result, the supervisor was counseled regarding the privacy of employee information.

- A VAMC review found that VA employees left detailed messages, including private medical information, with a patient's coworkers because of extreme difficulties in communicating with a veteran being monitored weekly for anticoagulant levels in his blood. Clinic management counseled the employees about releasing private patient

information and worked with the veteran to devise alternate means of reliable communications.

- A VHA review found instances where sensitive information was not safeguarded. As a result, it was recommended that the information security officer provide training to the dental service staff. It was also recommended that the facility conduct random computer checks in selected areas to ensure that the practice of safeguarding sensitive information is reinforced.

Facilities and Services

The responses to Hotline inquiries by VA management officials indicated that 25 allegations regarding deficiencies with facilities or the services provided by individual VA facilities were found to have merit and required corrective action. Examples of the issues follow.

- A VHA review substantiated inconsistencies in the nursing documentation of a veteran's death. The employee responsible was counseled. The need for adequate documentation of all changes in patient status was reinforced by management at nursing staff meetings.

- A VHA review substantiated the allegation that a veteran's wheelchair ramp was not installed in accordance with VA specifications. The facility engineering service will oversee the removal of the deficient ramp and construction of a new ramp that conforms to specifications. The total cost will be $3,250.

Veterans Benefits Administration

Receipt of VA Benefits

The responses to Hotline inquiries by management officials indicate that 21 allegations involving improprieties in the receipt of VA benefits were found to have merit and required corrective action. Examples of the issues follow.

- A VBA review substantiated the allegation that a veteran was fraudulently receiving 100 percent service-connected benefits. The rating was reduced to zero percent. The VARO will also investigate whether the veteran was receiving a union pension and SSA benefits during this same timeframe, which may affect the effective dates of the discontinuation of his VA benefits. The savings to VA is $550,000.

- A VBA review resulted in the proposed reduction of a veteran's benefits from 100 percent to 60 percent service-connected, to include the loss of individual unemployability, as a result of the veteran's employment. Projected savings to the Government is $372,456.

- A VBA review determined that a veteran receiving an income-based pension failed to report earnings from a home-based business. The VARO reduced the veteran's benefits to the amount awarded him for service-connected disabilities, resulting in a savings to VA of $91,224 based on the veteran's life expectancy.

- A VBA income verification match determined that a veteran in receipt of non-service connected pension benefits failed to report additional income, resulting in an overpayment of benefits of $42,459. The veteran's pension benefit was terminated as of February 1999 and recoupment action has been initiated against his account.

- A VBA review determined that a veteran in receipt of disability compensation benefits failed to notify the VARO of his numerous incarcerations. As a result, his disability C&P benefits were adjusted to reflect an overpayment of $22,362.

- A VBA review confirmed that a veteran, while incarcerated, continued to receive VA benefits checks that were mailed to his mother's address. This created an overpayment of $11,000.

Facilities and Services

The responses to Hotline inquiries by VA management officials indicated that 15 allegations regarding deficiencies with facilities or the services provided by individual VA facilities were found to have merit and required corrective action. Examples of the issues follow.

- A VBA review confirmed that an unidentified caller to the VARO changed a veteran's mailing address. Her compensation checks were forwarded to an incorrect address given by the caller. A further review found that none of the missing checks were negotiated, and one was returned to the Department of Treasury. The veteran has since set up a direct deposit account and received a lump sum payment to compensate for the missing checks. Furthermore, the VARO will make sure employees carefully verify the claimant's VA file number, Social Security number, service number, and dates of service before making an address change based on a telephone call.

- A VBA review found that delays in receiving all required information resulted in a significant delay in processing a veteran's educational benefits claim. Furthermore, as the veteran attempted to resolve the issue, a VARO employee hung up on him without providing the needed assistance. Management discussed customer service expectations with every case manager and apologized to the veteran for the problems he had encountered.

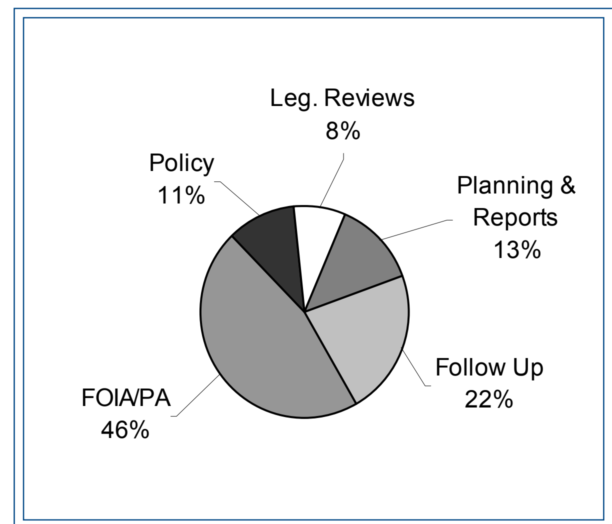
II. OPERATIONAL SUPPORT DIVISION

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 / Privacy Act requests; conducting policy review and development; producing strategic, operational, and performance plans; and overseeing Inspector General reporting requirements.

Resources

This Division has eight FTE assigned with the following allocation.



Overall Performance

Follow Up on OIG Reports

Operational Support is responsible for obtaining implementation actions on previously issued audits, inspections, and reviews with over $903 million of actual or potential monetary benefits as of September 30, 2003.

The Division maintains the centralized follow up system that provides 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 promptly and that VA

management officials implement corrective actions. VA's Deputy Secretary, as the Department's audit resolution official, resolves any disagreements about recommendations.

After obtaining information that showed management officials had fully implemented corrective actions, Operational Support closed 78 reports and 502 recommendations with a monetary benefit of $241 million during this period. As of September 30, 2003, VA had 71 open OIG reports with 255 unimplemented recommendations.

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

Operational Support processes all OIG FOIA and PA requests from Congress, veterans, veterans service organizations, VA employees, news media, law firms, contractors, complainants, the general public, and subjects of investigations. In addition, we process official requests for information and documents from other Federal Departments and agencies, such as the Office of Special Counsel and the Department of Justice. 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. Operational Support also processes 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 178 requests under the FOIA and PA and released 210 audit, investigative, and other OIG reports. Information was totally denied in 22 requests and partially withheld in 96 requests, because release would constitute an unwarranted invasion of personal privacy, interfere with enforcement proceedings, disclose the identity of confidential sources, disclose internal Departmental matters, or was specifically exempt from disclosure by statute. During this period, all FOIA cases received a written response within 20 workdays, as required. There are no requests pending over 6 months.

Electronic Report Distribution

The President's electronic Government initiatives, as described at http://www.whitehouse.gov/omb/egov/, aim to put Government at citizens' and employees' fingertips, making it more responsive and cost-effective. In keeping with this effort, electronic report distribution is an initiative to distribute OIG reports through a link to the OIG Web page. Individuals on the distribution list will receive a short e-mail describing the report, with a link directly to the report.

We believe this distribution method provides many advantages. It is fast and efficient, avoiding the cost and delays involved in producing large numbers of paper copies and the time problems of security screening of mail deliveries. It will greatly reduce the need to print paper copies. This approach also places OIG reports on our Web page as soon as they are issued.

During the reporting period, we established a staff and operating procedures, refined our distribution lists, and sent a message announcing and testing the system. We will begin using this method to distribute our CAP review reports in October 2003. We will expand it to include other OIG reports and information in the following months.

Review and Impact of Legislation and Regulations

Operational Support coordinated concurrences on 53 legislative, 50 regulatory, and 107 administrative proposals from the Congress, Office of Management and Budget, and VA. 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.

III. INFORMATION TECHNOLOGY AND DATA ANALYSIS DIVISION

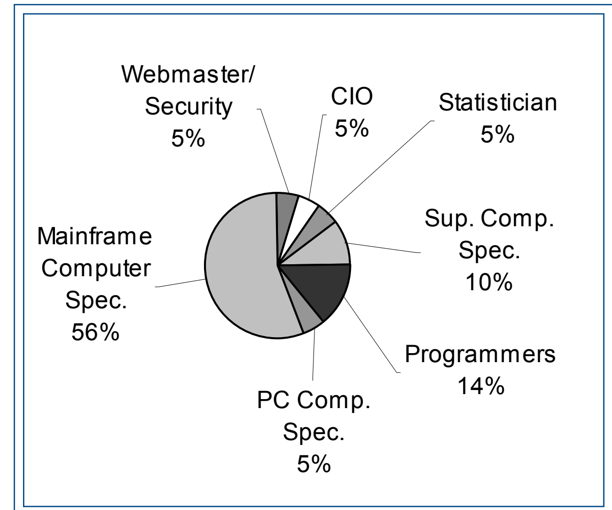
Mission Statement

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. Provide automated data processing technical support to all elements of the OIG and other Federal Government agencies needing information from VA files.

The Information Technology 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 OIG's Chief Information Officer and staff represent the OIG on numerous intra- and inter-agency IT organizations and are responsible for strategic IT planning for all OIG requirements. The Data Analysis Section in Austin, TX provides data gathering and analysis support to employees of the OIG, as well as VA and other Federal agencies, requesting information contained in VA automated systems. Finally, a member of the staff serves as the OIG statistician.

Resources

The Division has 22 FTE allocated in Washington, Austin, and Chicago. These FTE are devoted to the following areas.



Overall Performance

Master Case Index (MCI)

During this reporting period, we made major enhancements to the fugitive felon system, giving VBA and VHA the ability to respond back to the OIG electronically on action taken regarding the veterans. Since the fugitive felon system has been implemented, we have loaded data collected from the U.S. Marshals Service, FBI, California, and New York resulting in 7,668 warrants, 6,999 exact matches, and 669 partial matches.

We successfully upgraded the MCI application to a new version. Work continues on the migrated portion of MCI from the current client-server environment to a "web-enabled" *Oracle 9i* production database.

Internet and Electronic FOIA

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 website were accessed over 944,000 times by more than 137,000 visitors. The most popular reports were downloaded over 95,000 times, providing both timely access to OIG customers and cost avoidance in the reduced number of reports printed and mailed. OIG vacancy announcements accounted for an additional 5,400 downloads.

We posted the frequently requested audit report "Audit of VHA's Part-Time Physicians Time and Attendance," the May 8th and July 9th Congressional testimonies by the Inspector General, and the unclassified executive summary of the "Interagency Summary Report on Security Controls Over Biological Agents" in our electronic reading room in compliance with the Electronic FOIA. We posted 27 other CAP and audit reports, Office of Investigations press releases, and other OIG publications on the OIG website.

Information Management, Security, and Coordination

We provided hands-on training on the OIG's data encryption software to numerous OIG staff, including OIG investigators, auditors, and hotline analysts. We remediated virus and other information security incidents that affected OIG IT resources.

We participated in the development of Departmental policy and programs to improve VA information security, access, and resource utilization. We reviewed and provided comments on VA draft policy and proposals. Our comments addressed such issues as the possible duplication of staff in the proposed reorganization of the VA Office of Cyber Security, VA's cyber security professional certification program, VA's information security awareness course, the Office of Cyber Security's Review and Inspections Division reorganization, VBA's security policies on OIG access, VA's authentication and authorization infrastructure smart card project, and VA's central incident response capability support and customer response.

Statistical Support

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

For the reporting period, the OIG statistician provided statistical consultation and support on six research design and/or sampling plans for proposed audit projects and OHI proactive program evaluations, statistical support for all CAP reviews, and data concerning purchase card use at each facility.

IT Training Initiative

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

DATA ANALYSIS SECTION

The Data Analysis Section (DAS) develops proactive computer profiles that search VA computer data for patterns of inconsistent or irregular records with a high potential for fraud and refers these leads to OIG auditors and investigators for further review. The DAS provides technical assessments and support to all elements of the OIG and other governmental agencies needing information from VA computer files. Significant efforts include the following.

Education Fraud Referral

VA educational benefits involve a number of programs designed to provide veterans, servicepersons, and in some instances, dependents, with educational, training, and employment opportunities. DAS staff extracted data and conducted an analysis of payments. The staff analysis identified a series of suspect payments to several individuals, but which were all mailed to addresses belonging to a U.S. Navy recruiting office. The subsequent criminal investigation led to fraud charges against seven U.S. Navy personnel that totaled almost $400,000.

Fugitive Felon Matches

We continued to conduct matching of VA records to state and Federal files. The DAS staff matched records containing an additional 30,249 felony warrants from the New York State Police database against more than 10.5 million records contained in VA benefit system files. We identified over 500 additional fugitive felons receiving some type of benefit from VA. We improved the quality of the address information furnished from these matches by using specific payment codes and only payments made during the most recent 6 months. This selection criterion also reduced the number of VA benefit system records used in the match by almost 5.5 million.

Data Mining to Detect Potential Fraud in VA Computer Systems

The DAS took a proactive approach to finding and referring fraud by developing computer profiles that highlight anomalies from the typical VA work processes. An updated run of the VA C&P benefit death match program resulted in an additional 3,865 referrals to the Office of Investigations. The match also produced two additional referrals involving VA DIC payments. These cases included conflicting or missing data with respect to payee Social Security numbers.

The DAS staff played an active role in four OIG data mining committee meetings and provided data from 12 statistical matches to assess the potential for a formal matching plan. After consolidating related ideas, examining feasibility, and determining potential monetary impact, we identified 27 ideas to pursue from an original list of 75.

VBA Establishment and Authorization Permission

Two DAS employees identified a potential weakness in the C&P benefits system after attending the Benefits Delivery Network security administrator training in San Diego. Upon their return, they conducted an extensive analysis of the permissions granted to VBA employees. Working with VBA network and system access data, they verified that 203 individuals were granted permission to establish a claim under one system and permission to authorize that same claim in the other system. After referring the situation to the Office of Audit, a response from the Under Secretary for Benefits confirmed the problem and stated that VBA took action to correct the vulnerability.

Health Care Program Analysis and Review

During this reporting period, DAS staff adapted a hospital staffing model used by the U.S. Army to VA workload and staffing data, initially for one VA health care facility and later to the universal VA health care network. DAS also assisted Healthcare Inspections staff by extracting data in support of a surgical mortality study to examine the correlation between surgical outcomes and surgical workload. We also provided information to support a study on treatment and outcomes of patients presenting for treatment with dysphagia (swallowing and feeding problems) and dementia diagnoses. In addition, we identified by station the bills incorrectly sent to pensioner veterans for pharmacy co-payments and other treatment charges. In support of that review, we also identified actions taken by the VA Debt

Management Center to trigger refund offsets so that they could reverse them and suspend any collection.

Combined Assessment Program Reviews

The DAS provided technical support and data to all CAP reviews. We performed over 240 data extracts and associated reports in support of these reviews.

Preaward and Postaward Contract Reviews

The DAS provided technical support and data for three preaward and postaward contract reviews to identify better prices to VA and disclose overcharges by private sector contractors.

Assistance to Other Agencies

The DAS provided assistance to three Federal agencies seeking information contained in VA computer files. We received requests for assistance from the Department of Health and Human Services, the Department of Education, and the Department of Justice. One of the requests pertained to payments made to a hospital network indicted by a U.S. Attorney for inflated billing.

Other Workload

During the reporting period, the DAS completed 133 ad hoc requests for data that came from all OIG operational elements. We spent considerable effort working in support of an investigation of VA property management. The data request required locating, copying, and forwarding over 1,300 documents that showed the amounts of VA payments. In addition, we provided all Government purchase card activity for 102 individual employee cardholders.

IV. FINANCIAL AND ADMINISTRATIVE SUPPORT DIVISION

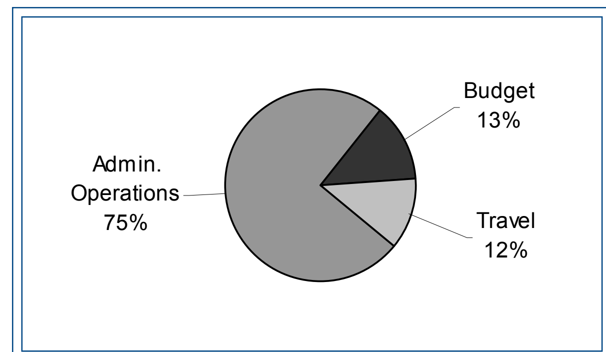
Mission Statement

Promote OIG organizational effectiveness and efficiency by providing reliable and timely financial and administrative support services.

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

Resources

Eight staff currently spend time across three functional areas in the following proportions.



Overall Performance

Budget

The staff assisted in the preparation of the FY 2005 budget submission and materials for associated hearings with VA and the Office of Management and Budget. The staff also assisted

in the conversion of the FY 2003 annual appropriation to a multi-year appropriation.

Travel

By the nature of our work, OIG personnel travel almost continuously. As a result, we processed 1,799 travel and 40 permanent change of station vouchers.

Administrative Operations

The administrative staff works closely with VA Central Office administrative offices and building management to coordinate various administrative functions, office renovation plans, telephone installations, and furniture and equipment procurement. In addition, we processed 134 procurement actions and reviewed and approved monthly the 35 statements received from the OIG's cardholders under the Government's purchase card program.

V. HUMAN RESOURCES MANAGEMENT DIVISION

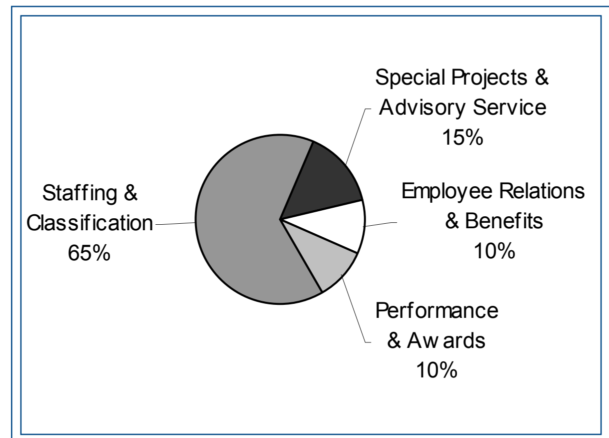
Mission Statement

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

The Division provides human resources management services for the entire OIG. These services include internal and external staffing, classification, pay administration, employee relations, benefits, performance and awards, and management advisory assistance. It also serves as liaison to the VA Central Offices of Human Resources and Payroll, as those offices process our actions into the VA integrated payroll and personnel system.

Resources

Seven FTE and one Student Career Experience Program trainee, committed to human resources management and support, currently expend time across the following functional areas.



Overall Performance

Human Resources Management

During this period, 48 new employees joined the OIG workforce and 18 employees departed. The staff processed over 160 recruitment, placement, and pay actions, 375 performance ratings, and 205 awards. We also provided support to accomplish the Federal Activities Inventory Reform Act reporting requirements.

The Eleventh Annual OIG awards ceremony took place in June 2003. The Inspector General presented awards for distinguished achievement, exceptional teamwork, outstanding initiative, and sustained superior achievement. Each Assistant Inspector General presented awards for the employee of the year and team accomplishment of the year. A total of 73 employees were recognized and an additional 22 employees were granted quality step increases.

We held an OIG New Employee Orientation Program in September 2003. Over 90 employees attended the 2-day program and learned about OIG organizational values, history, strategic goals, and organizational structure from the senior executive staff. The Secretary of the Department of Veterans Affairs spoke of VA's accomplishments the last three years and the special role an independent OIG fulfills for the Department. Also, a former prisoner of war in Viet Nam delivered an inspirational speech on the value of public service to the preservation of freedom in America.

VA Secretary Anthony J. Principi (L) is introduced as the keynote speaker for the OIG New Employee Orientation Program by VA Inspector General Richard J. Griffin.

The Inspector General established 25 co-operative education positions under the new OIG Student Career Experience Program. This program is one of several components of our OIG succession plan and is designed to bring well-educated and highly motivated college students into the workforce on a part-time, trial basis prior to permanent placement upon graduation. These positions are located in our field offices and at the Headquarters in a variety of occupational disciplines. We recruited at 62 colleges and universities throughout the country, including many Historically Black Colleges and Universities and Hispanic Association of Colleges and Universities. The first group of co-op students is expected to be on-board in early November. We also had several interns participating in the Cyber Security Scholarship Program.

Another component of our succession plan, the OIG Federal Career Intern Program, was established in September 2003. This program will aid us in recruiting on college campuses for full-time, entry-level positions in our major career fields. We also developed and implemented a new OIG Executive Development Program designed to create a pool of qualified candidates for Senior Executive Service positions.

OTHER SIGNIFICANT OIG ACTIVITIES

President's Council on Integrity and Efficiency

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

OIG Management Presentations

U.S. House of Representatives Lecture Series for House Page Interns

- The Inspector General made a presentation on the floor of the U.S. House of Representatives to 75 House page interns as part of their lecture series.

Inspector General Auditor Training Institute

- The Inspector General spoke at the banquet and graduation for the introductory auditor training class. The students appreciated the remarks on the benefits of having auditors, investigators, and inspectors working together within the VA OIG.

VBA Directors Conference

- The Inspector General made a presentation on internal controls and employee integrity.

11th Annual Leadership VA Alumni Association Forum

- The Inspector General participated in a panel discussion with other senior VA officials at this forum, responding to questions from the VA executives and managers attending.

American Institute of Certified Public Accountants

- The Assistant Inspector General for Auditing made a presentation to the American Institute of Certified Public Accountants National Governmental Accounting and Auditing Update Conference in Washington, DC. The topic was "*What is the Role of the Office of Inspector General in Facilitating Audit Outsourcing?*" The Director, Financial Audits Division made the similar presentation at their update conference in Phoenix, AZ.

Association of Government Accountants

- The Director, Financial Audits Division made a presentation to the Association of Government Accountants Northern Virginia chapter on *"What to Expect from a CFO Act Audit."* The presentation was on "*Hire an Independent Public Accountant or Perform the Audit In-House.*"

VA INFOSEC 2003 Security Conference and VA Information Technology Conference

- The Directors from the Central Office and IT Audit Divisions made presentations on the OIG security audit findings at the national VA information security conference in San Francisco, and national VA IT conference in Austin. The presentations included a demonstration on how scanning tools are used to complete network vulnerability assessments. Over 700 VA staff attended the security conference and over 2,000 attended the IT conference.

8th Annual Medicaid Drug Rebate Program Workshop

- Representatives from the OIG's Contract Review and Evaluation Division, VA's Office of General Counsel, and the National Acquisition Center's FSS Service conducted a half-day workshop for pharmaceutical industry representatives. The workshop covered the FSS program, Public Law 102-585 section 603 issues, and preaward reviews.

Office of Acquisition and Materiel Management's Acquisition Forums

- The IG Counselor and OIG representatives from the Contract Review and Evaluation Division made two presentations to VA contracting personnel. The presentations covered various aspects of contracting with affiliates for health care resources.

VHA Quality Management

- The Director, Los Angeles Healthcare Inspections Division made a presentation on inspection results pertaining to patient quality and services and on the CAP process to the quality management integration council and all quality managers in the field during their August 2003 national VHA broadcast.

VISN 20 Annual Readiness Consultant Training

- The Directors from the Los Angeles Healthcare Inspections Division and the Audit Operations Division made a joint presentation on CAP findings and quality management during the VISN training session.

Interagency Task Force

- The Deputy Assistant Inspector General for Healthcare Inspections and the Director, Bedford Healthcare Inspections Division, participated on an interagency committee comprised of the Offices of the Inspectors General of the Departments of Agriculture, Defense, Energy, and Health and Human Services to summarize audits, evaluations, and inspections on security controls over biological agents in the Federal Government. The task force issued a report that provided a summary of work on the status of security controls over biological agents and efforts to protect the general public from potential weapons of mass destruction.

Awards and Special Thanks

Military Order of the Purple Heart - Extraordinary Honors

- Resident Agent in Charge Danilo Whittaker, West Palm Beach, and Resident Agent in Charge Mike Keen, Nashville, were awarded the Commander's Law Enforcement Bronze Medal by the Military Order of the Purple Heart. The two

The St. Petersburg Times
St. Petersburg, FL
Monday, May 5, 2003

VA investigators earn rare honor

■ The local Military Order of the Purple Heart chapter gave two awards.

By KEVIN GRAHAM
Times Staff Writer

TAMPA — The local Military Order of the Purple Heart chapter honored two law enforcement agents from the U.S. Department of Veterans Affairs on Sunday.

Resident agents in charge Michael C. Keen and Danilo P. Whittaker received National Commander Citation awards.

It is unusual for a chapter of the Military Order of the Purple Heart, which are veterans organizations chartered by Congress exclusively for combat-wounded veterans, to recognize Veterans Affairs agents.

Keen, resident agent in charge

Michael C. Keen, left, debunked a veteran's story about a Korean War massacre. Danilo P. Whittaker solved a patient's death and busted up a drug ring accused of a murder.

One involved the conviction of a Veterans Affairs hospital nurse accused of injecting a veteran with a prescription drug without a doctor's consent, causing the veteran to die.

VA OIG special agents earned extraordinary honors by virtue of their work on three significant criminal investigations highlighted in previous semiannual reports. The Tampa chapter of the Military Order of the Purple Heart, an organization chartered by the U.S. Congress exclusively for combat-wounded veterans, presented the agents with the National Commander Citation awards.

Association of Government Accountants

- Senior auditor Lynn Scheffner served as President of the Kansas City chapter for the 2002-2003 program year. Under her leadership, the chapter received the platinum award, the association's highest level of recognition, and also an award for highest overall membership growth.

- Senior auditor Ken Myers served as the Midwest Region Vice President during the 2002-2003 program year. He received the platinum level award for his superior accomplishments. He also received a national special achievement award that recognizes younger association members for leadership ability and notable contributions toward improving financial management.

Letter of Appreciation

- Special Agent Jenny Pate received a letter of appreciation from a grateful veteran. The veteran sent the letter to the Special Agent in Charge of the VA OIG Northeast Field Office to let him know that he had kind and courteous people working for him. The veteran praised Special Agent Pate for helping resolve a problem with a VAMC.

OIG Congressional Testimony

- In May 2003, the Inspector General, accompanied by the Assistant Inspector General for Auditing, testified before the House Committee on Veterans' Affairs. The testimony discussed OIG's efforts to identify and eliminate criminal activity, waste, abuse, and mismanagement in programs administered by VA.

- In July 2003, the Inspector General, accompanied by the Assistant Inspector General for Auditing, testified before the Subcommittee on Benefits, House Committee on Veterans' Affairs. The testimony highlighted some of the OIG efforts to protect our Nation's veterans and to identify and eliminate criminal activity, waste, abuse, and mismanagement in the VA fiduciary and field examination program.

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				
02-02939-82 4/15/03	Combined Assessment Program Review of the VA Medical Center Huntington, WV			
03-00699-83 4/22/03	Combined Assessment Program Review of the VA Roseburg Healthcare System, Roseburg, OR	$65,000	$65,000	
03-00871-84 4/24/03	Combined Assessment Program Review of the VA Regional Office Atlanta, GA	$210,920	$210,920	
02-02171-89 4/30/03	Combined Assessment Program Review of North Chicago VA Medical Center, North Chicago, IL	$803,386	$803,386	
02-00987-96 5/20/03	Combined Assessment Program Review of the San Francisco VA Medical Center			$1,575
02-03094-101 5/22/03	Combined Assessment Program Review of the James A. Haley VA Medical Center Tampa, FL			
03-00760-102 5/27/03	Combined Assessment Program Review of the VA Medical Center Marion, IL	$24,862	$24,862	
03-01049-109 6/5/03	Combined Assessment Program Review of the VA Regional Office Muskogee, OK	$35,003	$35,003	
02-03376-112 6/12/03	Combined Assessment Program Review of the VA Regional Office St. Petersburg, FL			
03-01379-115 6/19/03	Combined Assessment Program Review of the Houston VA Medical Center, Houston, TX	$576,402	$576,402	
03-00758-117 6/27/03	Combined Assessment Program Review of the VA Regional Office Chicago, IL			
03-00759-125 7/10/03	Combined Assessment Program Review of the, VA Regional Office St. Paul, MN	$39,749	$39,749	
03-01387-126 7/14/03	Combined Assessment Program Review of the VA Medical Center Iron Mountain, MI			

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)

Report Number/ Issue Date	Report Title	OIG	Management	Questioned Costs
02-02172-129 7/14/03	Combined Assessment Program Review of the Washington, DC VA Medical Center	$235,656	$235,656	
03-00287-130 7/16/03	Combined Assessment Program Review of the VA Regional Office Los Angeles, CA	$500,000	$500,000	
03-01396-131 7/17/03	Combined Assessment Program Review of the Overton Brooks VA Medical Center Shreveport, LA			
03-00988-135 7/18/03	Combined Assessment Program Review of the VA Sierra Nevada Health Care System Reno, NV			
03-00700-140 7/29/03	Combined Assessment Program Review of the VA Medical Center Bay Pines, FL			
03-00821-141 7/31/03	Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA	$279,622	$279,622	
03-00752-143 7/31/03	Combined Assessment Program Review of the VA Medical Center Augusta, GA			
02-03264-148 8/7/03	Combined Assessment Program Review of the VA Medical Center New Orleans, LA	$631,295	$631,295	
03-01674-155 8/14/03	Combined Assessment Program Review of the VA Regional Office St. Louis, MO	$103,415	$103,415	
03-01404-161 8/14/03	Combined Assessment Program Review of the VA Medical Center Asheville, NC			
02-03214-163 8/21/03	Combined Assessment Program Review of the VA Medical Center Butler, PA			
03-01289-167 8/21/03	Combined Assessment Program Report of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA	$14,580	$14,580	
03-01144-170 8/26/03	Combined Assessment Program Review of the VA Hudson Valley Health Care System Montrose, NY			
03-00987-172 8/26/03	Combined Assessment Program Review of the VA Illiana Health Care System, Danville, IL	$138,158	$138,158	
03-00445-173 8/29/03	Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, WI	$125,000	$125,000	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM REVIEWS (Cont'd)				
03-01550-181 9/25/03	Combined Assessment Program Review of the VA Iowa City Health Care System, Iowa City, IA	$612,875	$612,875	
03-01855-179 9/30/03	Combined Assessment Program Review of the VA Medical Center Fayetteville, AR			
COMBINED ASSESSMENT PROGRAM SUMMARY REVIEWS				
03-01091-87 4/28/03	Summary Report of Combined Assessment Program Reviews at the Veterans Health Administration Medical Facilities October 2002 through March 2003			
03-02726-145 8/6/03	Summary Report of Combined Assessment Program Reviews at the Veterans Health Administration Facilities October 2002 through June 2003			
INTERNAL AUDITS				
02-01339-85 4/23/03	Audit of Veterans Health Administration's Part-Time Physician Time and Attendance			
02-02129-95 5/14/03	Audit of Veterans Health Administration's Reported Medical Care Waiting Lists			
02-01638-118 7/17/03	Management Letter, Audit of VA's Fiscal Years 2002 and 2001 Consolidated Financial StatementsGeneral Computer Controls Review at the Austin Automation Center			
02-01638-119 7/17/03	Management Letter, Audit of VA's Fiscal Years 2002 and General Computer Controls Review at the Philadelphia Information Technology Center			
02-01638-120 7/17/03	Management Letter, Audit of VA's Fiscal Years 2002 and 2001 Consolidated Financial Statements General Computer Controls Review at the Hines Information Technology Center			
02-01638-146 8/6/03	Management Letter, Audit of the Department of Veterans Affairs Consolidated Financial Statementsfor the Year Ended September 30, 2002			
02-01638-151 8/11/03	Management Letter, Audit of VA's Fiscal Years 2002 and 2001 Consolidated Financial StatementsCompensation and Pension System Review			
02-01638-152 8/11/03	Management Letter, Audit of VA's Fiscal Years 2002 and 2001 Consolidated Financial Statements Financial Management System Review			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use: OIG	Funds Recommended for Better Use: Management	Questioned Costs
INTERNAL AUDITS (Cont'd)				
02-01638-153 8/11/03	Management Letter, Audit of VA's Fiscal Years 2002 and 2001 Consolidated Financial Statements Loan Guaranty Systems Follow-Up Review			
02-01638-154 8/11/03	Management Letter, Audit of VA's Fiscal Years 2002 and 2001 Consolidated Financial Statements Personnel and Accounting Integrated Data System Review			
OTHER OFFICE OF AUDIT REVIEWS				
03-00440-80 4/2/03	Attestation of the Department of Veterans Affairs Detailed Accounting Submission for Fiscal Year 2003			
00-02021-86 4/25/03	Review of Veterans Benefits Administration Loan Guaranty Service Loan Refunding Practices			
01-01544-88 5/1/03	Accuracy of Data Used to Compute VA's Chronic Disease Care and Prevention Indices for FY 2001			
02-01198-103 5/23/03	Evaluation of Hotline Complaint Concerning Time and Attendance of Two Part-Time Physicians at Kansas City VA Medical Center			$13,102
03-02152-157 8/13/03	Evaluation of Allegations of Inappropriate Compensation and Pension Claims Processing at VA Regional Office Montgomery, AL			
03-02718-160 8/15/03	Report on the Department of Veterans Affairs Policies and Procedures to Give First Priority to the Location of New Offices and Other Facilities in Rural Areas			
CONTRACT REVIEWS *				
03-00531-90 4/29/03	Review of Proposal for Nuclear Imaging Systems Submittedby Philips Medical Systems Company Under Solicitation Number M6-Q7-02	$578,753		
02-00692-91 5/5/03	Verification of Novartis Opthalmics, Inc.'s Self-Audit Under Federal Supply Schedule Contract Number V797P-5281x			$69,113
00-02780-92 5/7/03	Settlement Agreement, Post Award Review of Medical Supply Manufacturer			$32,188

* 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)				
02-01956-93 5/7/03	Settlement Agreement, Gambro Renal Products, Inc., Federal Supply Schedule Contract No. V797P-3379j			$554,110
00-02842-97 5/7/03	Settlement Agreement, Ortho Biotech Products, L.P. Postaward Review of Federal Supply Schedule Contract Number V79P-5611M			$184,039
03-01267-94 5/13/03	Review of Federal Supply Schedule Proposal Submitted by Merck/Schering-Plough Distribution Services LLC, Under Solicitation Number M5-Q50A-03			
03-01686-98 5/13/03	Review of Inkine Pharmaceutical Company, Inc.'s Billings Under Federal Supply Schedule Contract Number V797P-5487x			$517
03-01506-100 5/21/03	Review of Proposal for Primary/Preventive Care Services at Two Community Based Outpatient Clinics in New Mexico Submitted by Health Centers of Northern New Mexico Under Request for Proposal Number 501-06-03			
03-01539-108 6/3/03	Review of Federal Supply Schedule Proposal Submitted by Karl Storz Endoscppy-America, Inc., Under Solicitation Number RFP-797-FSS-99-0025-R3	$2,364,736		
03-01685-111 6/9/03	Review of Proposal Submitted by Nebraska Health Systems Under Solicitation Number 636-0009-03 for Magnetic Resonance Imaging Services for the Department of Veterans Affairs Nebraska Western Iowa Health Care System			
00-02850-114 6/13/03	Settlement Agreement with a Pharmaceutical Manufacturer			$4,423,218
03-02009-113 6/17/03	Review of Proposal Submitted by New York University Under Solicitation	$23,626		
03-01866-116 6/19/03	Review of Proposal Submitted by the University of Pittsburgh Physicians Under Solicitation Number 646-54-02 for Kidney Transplant Services at Department of Veterans Affairs Pittsburgh Healthcare System	$343,396		
03-01361-121 7/1/03	Review of Proposal Submitted by University of Wisconsin Hospital & Clinics Under Solicitation Number RFQ 69D-066-03 for Organ Transplant Services for the Wm. S. Middleton Memorial Veterans Hospital, Madison, WI	$2,445,156		

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

CONTRACT REVIEWS (Cont'd)

Report Number/ Issue Date	Report Title	OIG	Management	Questioned Costs
03-00571-124 7/2/03	Review of Proposal Submitted by Duke University Medical Center, Under Solcitation Number RFP 558-50-02, for Radiation Oncology Services at the Department of Veterans Affairs Medical Center Durham, NC	$394,187		
03-01355-132 7/16/03	Review of Proposal Submitted by Varian Medical Systems, Inc., Under Solicitation Number M6-Q-16-02	$1,779,198		
00-02844-128 7/17/03	Review of Voluntary Disclosure and Refund Offer Janssen Pharmaceutica Products, L.P. Contract Number V797P-5770m			$1,984,278
03-02433-136 7/17/03	Review of Proposed Settlement by Novo Nordisk Pharmaceuticals, Inc. Under Federal Supply Schedule Contract Number V797P-5224x			$114,281
00-02848-127 7/18/03	Review of Voluntary Disclosure and Refund Offer Ortho-McNeil Pharmaceutical, Inc., Contract Number V797P-5387x			$42,902
03-01659-137 7/21/03	Review of Proposal Submitted by the University of Utah Hospital and Department of Radiation Oncology, Under Solicitation Number RFP 660-001-03, for Radiation Oncology Services to the Department of Veterans Affairs Salt Lake City Health Care System			
03-02359-138 7/22/03	Preaward Review of Private Diagnostic Clinic, PLLC's Proposal in Response to Request for Proposal Number 246-03-00204			
03-01896-139 7/23/03	Review of Federal Supply Schedule Proposal Submitted by Genentech, Inc.	$39,563		
02-02409-142 7/31/03	Verification of Ferring Pharmaceuticals Inc.'s Self-Audit Under Federal Supply Schedule Contract Number V797P-5228x			$48,045
03-01865-144 8/4/03	Review of Federal Supply Schedule Proposal Submitted by IVAX Pharmaceutical, Inc., Under Solicitation Number M5-Q50A-03	$2,605,595		
03-01941-156 8/12/03	Review of Proposal Submitted by the University of Nebraska Medical Center Under Solicitation Number 636-0003-03 for Nurse Practitioner and Pacer Technician Services at Department of Veterans Affairs Medical Center Omaha, NE	$82,988		

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
03-02360-158 8/14/03	Review of Proposal Submitted by the University of Pittsburgh Physicians Under Solicitation Number 646-37-03 for Cardiac Surgeon Services at the Department of Veterans Affairs Pittsburgh Health Care System	$472,715		
03-02426-162 8/19/03	Postaward Review of Contract Number V618P-3864a Awarded to University of Minnesota Physicians for Urology Surgeon Services for the Department of Veterans Affairs Medical Center Minneapolis, MN			
03-02401-168 8/20/03	Review of Proposal Submitted by Indiana University Under Solicitation Number 583-01-03 for Urology Surgeon Services at Richard L. Roudebush VA Medical Center			
03-02132-169 8/21/03	Review of Proposal Submitted by the University of Kentucky Medical Center Under Solicitation Number 596-9-03 for Emergency Cardio Thoracic Services for the Department of Veterans Affairs Medical Center Lexington, KY			
02-00816-164 8/22/03	Settlement Agreement			$1,023,835
03-02671-171 8/25/03	Review of Voluntary Disclosure and Refund Offer by Wyeth Pharmaceuticals Under Federal Supply Contract Number V797P-5460x			$36,614
03-02241-174 8/28/03	Review of Federal Supply Schedule Proposal Submitted by Zoll Medical Corporation Under Solicitation Number RFP-797-FSS-99-0025-R3	$2,488,538		
03-02242-175 9/3/03	Review of Bio-Technology General Corporation's Proposed Refund Offer Under Federal Supply Schedule Contract Number V797P-5178x			$44,743
03-01731-176 9/11/03	Review of Federal Supply Schedule Proposal Submitted by Johnson and Johnson Healthcare Systems, Inc., on Behalf of Janssen Parmaceutica Products, LP Under Solicitation Number M5-Q50A-03	$1,280,510		
03-02104-177 9/15/03	Review of Federal Supply Schedule Proposal Submitted by Dey, L.P. Under Solicitation Number M5-Q50A-03	$2,683,849		

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

HEALTHCARE INSPECTIONS

Report Number/ Issue Date	Report Title	OIG	Management	Questioned Costs
02-03297-99 5/23/03	Healthcare Inspection, Environment of Care Issues, VA Chicago Health Care System Chicago, IL			
02-02868-105 6/4/03	Healthcare Inspection, Environment of Care Issues, VA Medical Center St. Louis, MO			
02-00026-106 6/4/03	Healthcare Inspection, Evaluation of Quality Management in Veterans Health Administration Facilities			
02-02863-107 6/4/03	Healthcare Inspection, Alleged Suspicious Deaths, VA North Texas Health Care System Bonham, TX			
02-02374-126 7/21/03	Healthcare Inspection, Patient Care and Quality Management Issues, Hudson Valley Health Care System Montrose, NY			
03-00607-147 8/11/03	Healthcare Inspection, Alleged Substandard Care and Patient Abuse, VA North Texas Health Care System Dallas, TX			
02-03412-165 8/21/03	Healthcare Inspection, Patient Care Issues, VA Medical Center Washington, DC			
03-02153-166 8/21/03	Healthcare Inspection, Quality of Care Issues, VA Southern Nevada Healthcare System Las Vegas, NV			
03-01986-180 9/30/03	Healthcare Inspection, Patient Care Issue, VA Medical Center San Francisco, CA			

ADMINISTRATIVE INVESTIGATIONS

Report Number/ Issue Date	Report Title	OIG	Management	Questioned Costs
03-00182-79 4/4/03	Administrative Investigation, Physician Time and Attendance Issue, VA Medical Center North Chicago, IL			
03-00350-81 4/9/03	Administrative Investigation, Nepotism Issue, VA Medical and Regional Office Center Fargo, ND			
03-00346-104 5/30/03	Administrative Investigation, Acceptance of Compensation and Travel Payments Issues, Office of Regional Counsel, Indianapolis, IN			
03-01008-110 6/16/03	Administrative Investigation, Physician Time and Attendance Issue, VA New York Harbor Healthcare System, New York, NY			$10,168

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

ADMINISTRATIVE INVESTIGATIONS (Cont'd)

Report Number/ Issue Date	Report Title	OIG	Management	Questioned Costs
01-02549-122 7/3/03	Administrative Investigation, Contract Issues, Office of Resolution Management, VA Central Office Washington, DC			
03-00399-134 7/24/03	Administrative Investigation, Impartiality Issue, VA Medical Center Salt Lake City, UT			
01-02549-123 7/25/03	Administrative Investigation, Contract Issues, Acquisition Operations Service, VA Central Office Washington, DC			
03-00047-133 7/25/03	Administrative Investigation, Inappropriate Conduct and Use of Franked Envelopes Issues, VA Medical Center Lexington, KY			
03-00281-149 8/15/03	Administrative Investigation, Acceptance of Speaking Fees and Gifts Issues, VA Medical Center Kansas City, MO			
02-01429-150 8/15/03	Administrative Investigation, Temporary Duty Travel Issues, Ralph H. Johnson VA Medical Center Charleston, SC			
03-00460-159 8/18/03	Administrative Investigation, Government Vehicle Use Issue, VA Regional Office Chicago, IL			
03-01345-178 9/17/03	Administrative Investigation, Contract and Telephone Use Issues, Edith Nourse Rogers Memorial Veterans Hospital Bedford, MA			
TOTAL:	**104 Reports**	**$21,978,733**	**$4,395,923**	**$8,582,728**

APPENDIX B

STATUS OF OIG REPORTS UNIMPLEMENTED FOR OVER 1 YEAR

The Federal Acquisition Streamlining Act of 1994 provides guidance on prompt management decisions and implementation of OIG recommendations. It states a Federal agency shall complete final action on each recommendation in an OIG report within 12 months after the report is finalized. If the agency fails to complete final action within this period, the OIG will identify the matter in their semiannual report to Congress until the final action is completed. This appendix summarizes the status of OIG unimplemented reports and recommendations.

The OIG requires that management officials provide documentation showing the completion of corrective actions on OIG recommendations. In turn, OIG reviews 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, OIG closes the recommendation. If the actions do not implement the recommendation, we continue to monitor progress.

The number of reports in this category declined significantly, dropping from 80 in FY 1996 to only 8 as of September 30, 2003. The following chart lists the total number of unimplemented OIG reports and recommendations by organization. It also provides the total number of unimplemented reports and recommendations issued over 1 year ago (September 30, 2002, and earlier).

Unimplemented OIG Reports and Recommendations

VA Office	Total		Isued 9/30/02, and Earlier	
	Repts	Recoms	Repts	Recoms
VHA	36	149	4	10
MGMT	24	44	0	0
VBA	8	26	3	9
I&T	2	21	0	0
VHA/S&LE	1	15	1	15
Total	**71**	**255**	**8**	**34**

Office of Acquisition and Materiel Management (A&MM)
Office of Information and Technology (I&T)
Office of Security and Law Enforcement (S&LE)

The OIG is particularly concerned with two reports on VHA operations (issued in 1997 and 1999) and two reports on VBA operations (both issued in 2000) with recommendations that still remain open. The following information provides a summary of reports over a year old with open recommendations.

Veterans Health Administration

Unimplemented Recommendations and Status

Report: *Internal Controls Over the Fee-Basis Program, 7R3-A05-099, 6/20/97*

Recommendations: The Under Secretary for Health should improve the cost effectiveness of home health services by:

1. Establishing guidelines for contracting for such services.
2. Providing contracting officers with benchmark rates for determining the reasonableness of charges.

Status: The Chief Consultant for Geriatrics and Extended Care has proposed benchmark rates for home and hospice care programs. The policy has been set forth in a draft home health and hospice care reimbursement handbook. No planned completion date is available.

****

Report: *Evaluation of VHA's Income Verification Match Program, 9R1-G01-054, 3/15/99*

Recommendations: The Under Secretary for Health should:

1. Require the Chief Network Officer to ensure that VISN Directors establish performance standards and quality monitors, and strengthen procedures and controls for means testing activities and billing and collection of Health Eligibility Center (HEC) referrals to include reviewing a sample of cases to verify appropriate billing and compliance with the 60-day billing standard and to determine why unbilled referrals were not billed and taking appropriate corrective action.
2. Requiring the Chief Information Officer to develop performance measures and monitor periodic performance reports to ensure the HEC performs multiple year income verification.
3. Expedite action to centralize means testing activities at the HEC.

Status: The VHA Chief Business Officer has initiated the following:
1. Software to automatically generate a bill on the 61st day of referral is in development. It is scheduled for national release in the first quarter, FY 2004.
2. The HEC is still on target for the first quarter, FY 2004 to do multiyear cases. The initial requests for 2002 income data has been submitted and received from both the Internal Revenue Service and Social Security Administration with plans to start the income verification process for income year 2002 in October 2003. When those cases are opened, the software will concurrently identify the need to do a second year review and notify staff if a second year income review is due. The HEC staff will then be able to concurrently process both income years. The HEC anticipates beginning this process in the first quarter, FY 2004.
3. VHA will be implementing an alternative financial assessment renewal process that involves leveraging their required income verification responsibility. Full implementation of the revised financial assessment process based upon the IVM program is dependent upon substantial modification to VHA's information system; it is expected to be implemented by the first quarter, FY 2005.

****

Report: *Administrative Investigation, Irregularities in Employee Relocation Reimbursements and the Workers' Compensation Program, VAMC West Palm Beach, FL,* 00-01632-117, 7/20/01

Recommendations: The VISN 8 Director should:

1. Take appropriate administrative action against the VAMC Director for allowing the Chief, Human Resources Management Service, and the Chief, Business Office to avoid Federal requirements to report job-related injuries, and bill associated costs, to the Department of Labor.
2. Take appropriate administrative action against the VAMC Director for not ensuring that VAMC employees are adequately informed of their workers' compensation program rights, and for improperly denying three employees continuation of pay benefits.
3. Ensure that employees who were injured at the VAMC since the VAMC Director became Director have received all the benefits to which they are entitled.

Status:
1 and 2. The VISN must consider the findings and recommendations of the most recent board of investigation. This board completed its site visit September 18, 2003. The VISN will finalize appropriate action upon receipt of the board's report, which is anticipated in the first quarter, FY 2004.
3. The appointed board of investigation completed their site visit. The VISN awaits their findings and recommendations in order to respond to the current status of the workers' compensation program and whether staff has been provided all of the benefits to which they are entitled.

****

Report: *Audit of the Medical Care Collection Fund Program,* 01-00046-65, 2/26/02

Recommendations: The Under Secretary for Health should improve Medical Care Collection Fund program operations by:

1. Improving medical record documentation so that treatment is coded accurately and properly billed.
2. Ensuring that VA medical facilities use the preregistration software as required.

Status: This requires action by two VHA offices.
1. The VHA Information Office is revising the health record and heath information handbook that reflects the enhancements. No planned completion date is available.
2. The VHA Chief Business Office has submitted a project request for an enhancement to the VHA diagnostic measures to include a new national report on the use of the preregistration software. The addition of this report to the diagnostic measures Website will allow VHA to ensure that facilities are using the software. This enhancement is scheduled for implementation by the third quarter, FY 2004.

****

Joint (Veterans Health Administration and Office of Security and Law Enforcement)

Unimplemented Recommendations and Status

Report: *Review of Security and Inventory Controls Over Selected Biological, Chemical, and Radioactive Agents Owned by or Controlled at VA Facilities,* 02-00266-76, 3/14/02

Recommendations: The Under Secretary for Health, in conjunction with senior policy, research, and operations manages, need to:

1. Redefine and strengthen security and access requirements and procedures for safeguarding high-risk agents and materials used in VA facilities, such as the agents on the Centers for Disease Control and Prevention Select Agents List, other biological agents, toxic chemicals, and certain pharmaceuticals that might be targeted for use by terrorists.
2. Improve personnel access controls and reduce vulnerabilities to theft of selected agents by implementing measures such as the consistent use of photo identification badges with expiration dates, installation of electronically controlled entry points to and from sensitive areas, and use of key-card systems, video surveillance, and/or biometric systems.
3. Review documents related to VA leased-space to others for research use (e.g., to an affiliated university) to ensure that VA's agreements define security responsibilities and limitations.
4. Clarify VA's accountability and responsibilities for actions of non-VA persons supervising VA or non-VA research in VA facilities or in VA space leased to other institutions.
5. Strengthen controls for authorizing and procuring high-risk materials and agents including biological agents, and ensure that inventory, transfer, and validated destruction policies and procedures account for biological agents and chemicals at all times. Additionally, procedures should outline appropriate requirements for the use of witnesses to verify transfer and destruction processes.
6. Require managers to transfer, dispose of, or establish delimiting dates on select agents no longer in use and stored in research and clinical laboratories.
7. Reevaluate the extent of compliance with radiation safety and handling/delivery procedures, particularly vendor deliveries after regular working hours and on weekends. In addition, facility managers should require contractors and vendors to provide evidence that background and legal histories on their employees are checked before they are allowed to access sensitive VA areas.
8. Strengthen human resource management controls and procedures to consistently verify or update non-citizens' legal residence or employment status while working in VA facilities or on VA matters, including students and contractors.
9. Reevaluate the adequacy of security clearance level requirements for employees who could have access to or work with highly sensitive agents and materials.
10. Take action on non-citizen employees without valid legal status and notify appropriate legal authorities.
11. Take action on any noncitizens with access to VHA research and clinical laboratories if they are considered "restricted persons" according to the USA PATRIOT Act.
12. Ensure clearance and checkout procedures extend to employees without compensation and contract employees.
13. Issue guidance to revise local disaster plans to include provisions for responding to terrorist activities.
14. Direct managers at all facilities to perform vulnerability assessments of their physical research and clinical laboratories and consistently implement security measures.
15. Provide researchers and other appropriate personnel necessary training on security issues, including security of high-risk and sensitive agents, and procedures to forward requests for research articles through their managers and the facility Freedom of Information Act officer.

Status: This report requires action by VHA and the Office of Security and Law Enforcement (S&LE), part of the Office of Policy, Planning, and Preparedness. On March 21, 2002, the VA Deputy Secretary requested the Under Secretary for Health and the then-Assistant Secretary for Policy and Planning to provide him a joint report that certifies that all the recommendations have been completed by September 30, 2002. As of September 30, 2003, 15 of 16 recommendations remain unimplemented pending additional actions by the Department. To comply with Federal regulations, VHA needs to ensure that field managers have fully addressed the security and inventory controls over sensitive or dangerous biological agents, chemicals, and radioactive materials owned by or controlled at VA facilities, that might be used as weapons of mass destruction - not just the Center for Disease Control and Prevention-select agents that are used in some of VHA's research laboratories.

The OIG recommendations made to VHA are consistent with requirements outlined in the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (42 Code of Federal Regulations 73). Also, the Department of Health and Human Services (HHS) issued new regulations in December 2002 that include guidance for laboratories working with particularly sensitive bioagents and toxins, often generally described as "select agents." While not including select agents or toxins in a naturally occurring environment if they have not been intentionally introduced, cultivated, collected, or otherwise extracted from natural sources, the HHS regulations apply to facilities using various select agents and toxins. The HHS requirements are designed to implement provisions of the Public Health Security and Bioterrorism Preparedness and Response Act to provide protection against the effects of misuse of select agents and toxins, whether inadvertent or the result of terrorist acts against the United States homeland or other criminal acts. The HHS guidance includes registration requirements and instructions regarding personnel, risk assessments, and inventory controls. The OIG recommendations are also consistent with the United and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT) Act of 2001, which prohibits certain restricted persons from accessing select agents.

VHA's Office of Research and Development plans on systematically reviewing all field research sites over the next 3 years, as part of its infrastructure program, to identify and fund equipment needs that include security devices. In addition, on November 20, 2002, VHA issued requirements applicable to research laboratories in VHA Directive 2002-075, "Control of Hazardous Materials in VA Research Laboratories." This Directive included instructions on accountability for select agents, personnel/access measures, and physical security requirements, but it does not apply to VHA's clinical laboratories that are designated at biosafety level 3. It is unclear to us at this time whether any biosafety level 3 clinical laboratories are configured to safely handle the more sensitive select agents or toxins. Since our findings did not attest to accuracy of the October 2001 national inventory, we are also unclear whether these particular clinical laboratories may still have these sensitive items in their possession for some clinical or educational purpose. During the October 2001 national inventory effort, VHA "provided recommendations" to clinical laboratory managers on retention, storage, and security of those agents. No formal policy was issued. VHA officials stated that clinical laboratories "have not generally been secured due to accessibility requirements" (i.e., that they be open and accessible to medical staff) and also "the low risk for these laboratories." In addition, VHA's clinical laboratory managers "are expected to operate in accordance with the recommendations" of VHA's Biohazardous Materials Task Force as well as an issued joint memorandum. The memorandum, issued on July 29, 2002, was an interim measure to immediately address laboratory safety and security, and it contained instructions for conducting assessments and making immediate changes to the physical security of VHA clinical and research laboratories. The memorandum instructed field facilities to apply already existing Department physical security standards. Based on that memorandum, OS&LE inspectors began reviewing VHA clinical and research laboratory security as part of routine, on-site program inspections. However, VHA also published an Emergency Management Guidebook with requirements for plans that are to include security of sensitive and critical locations in VA facilities, as part of facilities' hazard vulnerability assessments. There may be other sensitive

and critical locations in VHA facilities besides laboratories, such as those storing or using particularly dangerous chemicals or gases, or those with irradiators.

We are reviewing VHA's ongoing actions and working with officials on resolving the implementation of the recommendations. In addition, VA's S&LE office has drafted a revised VA Directive and Handbook 0710, "Personnel and Classified Information Security" and it is in Department-wide concurrence. After receiving concurrences, they will both be published. Also in January 2003, the office began revising VA Directive and Handbook 0730, "Security and Law Enforcement." No planned date for publication is available. We are continuing our follow up of these actions as well.

Because of the national significance of these important issues, public health safety, and the VA Departmental guidance forthcoming or still needed, it is important that VA senior managers responsible for facilities that possess or handle biological agents, chemicals, or radioactive substances or materials, that could be used as weapons of mass destruction or for significant public harm, provide a certification that they have implemented all OIG recommendations and are in compliance with applicable VA and other guidelines.

****

Veterans Benefits Administration

Unimplemented Recommendations and Status

Report: *Audit of the C&P Program's Internal Controls at VARO St. Petersburg, FL,* 99-00169-97, 7/18/00

Recommendations: The Under Secretary for Benefits should:

1. Establish a positive control Benefits Delivery Network (BDN) system edit keyed to employee identification number that ensures employee claims are adjudicated only at the assigned regional office of jurisdiction and prevents employees from adjudicating matters involving fellow employees and veterans service officers at their home office.
2. Establish a BDN system field for third-person authorization and a control to prevent release of payments greater than $15,000 without the third-person authorization.
3. Determine the feasibility of direct input and storage of rating decisions in BDN.
4. Issue guidelines for the proper and effective handling of drop-mail to ensure continued entitlement.
5. Take steps necessary to make use of Social Security numbers as employee identification numbers, and tie BDN access to Social Security numbers.

Status:
1 and 2. As the Modern Award Processing system is designed, this control will be incorporated. This step will be implemented in the final stages of deployment, scheduled for the end of the fourth Quarter, FY 2004.
3. National deployment of the Rating Board Automation 2000 program addresses this recommendation. As of July 2003, the program was at 97 percent usage nationally. There are some defects in the program that requires usage of an old program for some less common types of cases. An updated version of the program that fixes the defects cannot take place until Windows 2000 is released nationally in November 2003.
4. The procurement package for a nationwide address locator service was awarded in September 2003. After securing the software, preparing new manual procedures, and training field users, we expect that field offices will be using this new change of address locator by the end of the first quarter of FY 2004.
5. VBA awarded the BDN database software conversion contract and the estimated completion date is September 2004. After the conversion, VAROs will have a single logon capability across geographical

regions. VBA is also modifying the BDN to track employee activity. When the BDN change is made, employee access and the transactions they generate will be identified and filed by their Social Security number. The estimated completion date is November 2003.

****

Report: *Audit of VBA's Income Verification Match Results*, 99-00054-1, 11/8/00

Recommendation:

1. The Under Secretary for Benefits should complete necessary data validation of beneficiary identifier information contained in C&P master records to reduce the number of unmatched records with SSA. *(This is a repeat recommendation from the 1990 OIG report.)*

Status: The C&P Service determined that an additional modification to the processing of data was required before releasing the monthly Social Security number verification lists to VAROs. The modification is currently in the concurrence process. Change 181 to M21-1, part IV, chapter 31 providing updated procedures for working the verification lists was approved in August 2003 and will be published soon.

****

Report: *Follow Up Evaluation of the Causes of C&P Overpayments,* 01-00263-53, 2/20/02

Recommendation:

1. The Under Secretary for Benefits should reduce C&P benefit overpayments by revising processing procedures and clarifying VA policy to proactively suspend benefits when bad addresses cannot be resolved.

Status: The procurement package for a nationwide address locator service was awarded in September 2003. After securing the software, preparing new manual procedures, and providing training to field users, VBA expects that field offices will be using this new change of address locator by the end of the first quarter, FY 2004.

****

APPENDIX C

INSPECTOR GENERAL ACT REPORTING REQUIREMENTS

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

IG Act References	Reporting Requirement	Page
Section 4 (a) (2)	Review of legislation and regulations	50
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-55
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-55
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	71 (App. B)
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	80 (App. C)
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	61 to 70 (App. A)
Section 5 (a) (7)	Summary of each particularly significant report	i to vi
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	81 (Table 1)
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	82 (Table 2)
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	80 (App. C)
Section 5 (a) (11)	Significant revised management decisions	80 (App. C)
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	80 (App. C)
Section 5 (a) (13)	Information described under section 05(b) of the Federal Financial Management Improvement Act of 1996 (Public Law 104-208)	80 (App. C)

Prior Significant Recommendations Without Corrective Action and Significant Management Decisions

The IG Act requires identification of: (i) significant revised management decisions, and (ii) significant management decisions with which the OIG is in disagreement. During this 6-month period, there were no reportable instances under the Act.

Obtaining Required Information or Assistance

The IG Act requires the OIG 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 the Act.

Federal Financial Management Improvement Act of 1996 (Public Law 104-208)

The IG Act requires the OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with the requirements of Public Law 104-208. The OIG has reported in our Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2002 and 2001 (Report Number 02-01638-47, Issued 1/22/03), that corrective action dates in the VA remediation plan are all in the future.

Reports Issued Before this Reporting Period Without a Management Decision Made by the End of the Reporting Period

The IG Act requires a summary of audit reports issued before this reporting period for which no management decision was made by the end of the reporting period. There were no internal OIG reports unresolved for over 6 months. However, there were four contract review reports unresolved because a contracting officer decision has not been made for over 6 months. These contract review reports issued in 2002 will be closed after the OIG receives the contracting officer price negotiation memorandum following contract awards.

Statistical Tables 1 and 2 Showing Number of Unresolved Reports

As required by the IG Act, Tables 1 and 2 provide statistical summaries of unresolved and resolved reports for this reporting period. Specifically, they provide summaries 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 with potential monetary benefits that remained unresolved at the end of the period.

TABLE 1 - RESOLUTION STATUS OF REPORTS WITH QUESTIONED COSTS

This table provides the resolution status information required by the IG Act. It summarizes the reports with questioned costs.

RESOLUTION STATUS	NUMBER OF REPORTS	QUESTIONED COSTS (In Millions)
No management decision by 9/30/02	0	$0
Issued during reporting period	18	$15.8
Total Inventory This Period	**18**	**$15.8**
Management decision during reporting period		
Disallowed costs (agreed to by management)	18	$15.8
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Period	**18**	**$15.8**
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 costs OIG recommends be disallowed by the contracting officer or other management official. Costs normally result from a finding that expenditures were not made in accordance with applicable laws, regulations, contracts, 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 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 or management officials have determined that VA will not pursue recovery of funds.

TABLE 2 – RESOLUTION STATUS OF REPORTS WITH RECOMMENDED FUNDS TO BE PUT TO BETTER USE BY MANAGEMENT

This table provides the resolution status information required by the IG Act. It summarizes the reports with recommended funds to be put to better use by management.

RESOLUTION STATUS	NUMBER OF REPORTS	RECOMMENDED FUNDS TO BE PUT TO BETTER USE (In Millions)
No Management decision by 9/30/03	8	$20.3
Issued during reporting period	14	$44.0
Total Inventory This Period	**22**	**$64.3**
Management decisions during reporting period		
Agreed to by management	11	$7.1
Not agreed to by management	0	$0.0
Total Management Decisions This Period	**11**	**$7.1**
Total Carried Over to Next Period	**11**	**$57.2**

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

OIG OPERATIONS PHONE LIST

Investigations

Headquarters Investigations Washington, DC .... (202) 565-7702

Northeast Field Office (51NY) New York, NY .... (212) 951-6307

- Boston Resident Agency (51BN) Bedford, MA .... (781) 687-3138
- Newark Resident Agency (51NJ) Newark, NJ .... (973) 297-3339
- Pittsburgh Resident Agency (51PB) Pittsburgh, PA .... (412) 784-3818
- Washington Resident Agency (51WA) Washington, DC .... (202) 530-9191

Southeast Field Office (51SP) Bay Pines, FL .... (727) 398-9559

- Atlanta Resident Agency (51AT) Atlanta, GA .... (404) 929-5950
- Columbia Resident Agency (51CS) Columbia, SC .... (803) 695-6707
- Nashville Resident Agency (51NV) Nashville, TN .... (615) 695-6373
- West Palm Beach Resident Agency (51WP) West Palm Beach, FL .... (561) 882-7720

Central Field Office (51CH) Chicago, IL .... (708) 202-2676

- Denver Resident Agency (51DV) Denver, CO .... (303) 331-7673
- Cleveland Resident Agency (51CL) Cleveland, OH .... (440) 717-2832
- Kansas City Resident Agency (51KC) Kansas City, KS .... (913) 551-1439

South Central Field Office (51DA) Dallas, TX .... (214) 253-3360

- Houston Resident Agency (51HU) Houston, TX .... (713) 794-3652
- New Orleans Resident Agency (51NO) New Orleans, LA .... (504) 619-4340

Western Field Office (51LA) Los Angeles, CA .... (310) 268-4269

- Phoenix Resident Agency (51PX) Phoenix, AZ .... (602) 627-3252
- San Diego Resident Agency (51SD) San Diego, CA .... (619) 400-5326
- San Francisco Resident Agency (51SF) Oakland, CA .... (510) 637-6360
- Seattle Resident Agency (51SE) Seattle, WA .... (206) 220-6654, ext 31

OIG OPERATIONS PHONE LIST (CONT'D)

Healthcare Inspections

Central Office Operations Washington, DC .... (202) 565-8305
Healthcare Regional Office Washington (54DC) Washington, DC .... (202) 565-8452
Healthcare Regional Office Atlanta (54AT) Atlanta, GA .... (404) 929-5961
Healthcare Regional Office Bedford (54BN) Bedford, MA .... (781) 687-2134
Healthcare Regional Office Chicago (54CH) Chicago, IL .... (708) 202-2672
Healthcare Regional Office Dallas (54DA) Dallas, TX .... (214) 253-3330
Healthcare Regional Office Los Angeles (54LA) Los Angeles, CA .... (310) 268-3005

Audit

Central Office Operations Washington, DC .... (202) 565-4625
Central Office Operations Division (52CO) Washington, DC .... (202) 565-4434
Contract Review and Evaluation Division (52C) Washington, DC .... (202) 565-4818
Financial Audit Division (52CF) Washington, DC .... (202) 565-7913
Information Technology Division (52IT) Washington, DC .... (202) 565-5826
Veterans Health and Benefits Division (52VH) .... (202) 565-8447
Operations Division Atlanta (52AT) Atlanta, GA .... (404) 929-5921
Operations Division Bedford (52BN) Bedford, MA .... (781) 687-3120
Operations Division Chicago (52CH) Chicago, IL .... (708) 202-2667
Operations Division Dallas (52DA) Dallas, TX .... (214) 253-3300
Austin Residence (52AU) Austin, TX .... (512) 326-6216
Operations Division Kansas City (52KC) Kansas City, MO .... (816) 426-7100
Operations Division Los Angeles (52LA) Los Angeles, CA .... (310) 268-4335
Operations Division Seattle (52SE) Seattle, WA .... (206) 220-6654

APPENDIX E

GLOSSARY

AIDS	Acquired Immune Deficiency Syndrome
BDN	Benefits Delivery Network
C&P	Compensation and Pension
CAP	Combined Assessment Program
DAS	Data Analysis Section
DEA	U.S. Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FOIA/PA	Freedom of Information Act/Privacy Act
FSS	Federal Supply Schedule
FTE	Full Time Equivalent
FY	Fiscal Year
GSA	General Services Administration
HEC	Health Eligibility Center
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HUD	Department of Housing and Urban Development
I&T	Office of Information and Technology
IG	Inspector General
IT	Information Technology
LGS	Loan Guaranty Service
MCI	Master Case Index
NCA	National Cemetery Administration
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
QM	Quality Management
S&LE	Office of Security and Law Enforcement
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
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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

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

The report is also available on our website:

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

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

Cover photo of
Vietnam Veterans Memorial
Courthouse Square, Prescott, Arizona by
Joseph M. Vallowe, Esq.
VA OIG, Washington, DC

Help VA's Secretary ensure the integrity of departmental operations by reporting suspected criminal activity, waste, or abuse in VA programs or operations to the Inspector General Hotline.

(CALLER CAN REMAIN ANONYMOUS)

To Telephone:	**(800) 488-8244**
	(800) 488-VAIG
To FAX:	**(202) 565-7936**
To Send Correspondence:	**Department of Veterans Affairs** **Inspector General Hotline (53E)** **P.O. Box 50410** **Washington, DC 20091-0410**
Internet Homepage:	**http://www.va.gov/oig/hotline/hotline.htm**
E-mail Address:	**vaoighotline@mail.va.gov**

Department of Veterans Affairs
Office of Inspector General
Semiannual Report to Congress

April 1, 2003 - September 30, 2003