"To care for him who shall have borne the battle and for his widow and his orphan."
Abraham Lincoln

Office of Inspector General
Department of Veterans Affairs

Semiannual Report to Congress
April 1, 2004 - September 30, 2004

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, 2004. 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 105 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 over $1.17 billion in monetary benefits, for an OIG return of $37 for every dollar invested.

Our criminal investigators closed 468 investigations involving a wide variety of criminal activity directed at VA personnel, patients, programs, or operations. Special agents conducted investigations that led to 779 arrests, indictments, convictions, and pretrial diversions. They also produced nearly $302 million in monetary benefits to VA . Additionally, the efforts of our agents led to the apprehension of 181 fugitive felons nationwide.

One of our more significant investigations involved a multi-agency task force that was formed to investigate allegations of the sale and distribution of illegal narcotics in and around a VA medical center (VAMC). A confidential informant developed by the OIG was placed inside the facility and spent almost 1 year gathering information regarding illegal activities. This informant made over 70 monitored purchases of illegal drugs that resulted in the arrest of over 50 individuals. To date, nearly half of that number have already been convicted.

In addition to the sale of illegal narcotics, pharmaceuticals were being diverted from the VAMC pharmacy. These included expensive blood pressure medications and sexual impotence drugs. Investigation into this matter resulted in the arrest of two VAMC pharmacy employees, a Disabled American Veterans service officer, and a former VA employee on charges of violation of state pharmaceutical statutes.

Audit oversight focused on determining how to improve VA services to veterans and their families. Our follow-up audit of the Workers' Compensation Program (WCP) found previous OIG audit recommendations to: (i) enhance VA's case management and fraud detection efforts, and (ii) avoid inappropriate dual benefit payments, were not fully implemented. As a result, we found opportunities to reduce WCP costs by $696.2 million over the projected lifetime of claimants on the rolls. Preaward and postaward contract reviews identified monetary benefits of over $122.6 million resulting from actual or potential contractor overcharges to VA. This amount included contract review recoveries of $1.1 million deposited into VA's revolving supply fund.

Our health care inspectors focused on quality of care issues in VA. Inspectors visited a number of facilities to respond to Congressional and other special requests concerning health care related matters. We also completed four summary evaluation reports that should assist Veterans Health Administration's managers: (i) improve the quality of care and safety of patients in community residential care programs; (ii) identify violent patients and minimize the risk to employees, patients, and others visiting VA facilities from threatening and violent patient behaviors; (iii) strengthen quality management; and (iv) improve the management of nursing resources, facilitate nursing recruitment and retention efforts, and enhance nurses' job satisfaction. Our nurse staffing review identified areas where $42.4 million in costs could be better used.

We conducted an evaluation of selected patient care and administrative issues and the attempted deployment of the Core Financial and Logistics System (CoreFLS) at VAMC Bay Pines. We confirmed reports of substandard patient care and services at the VAMC and found that many of the conditions existed prior to the deployment of CoreFLS. We concluded that the contracting and monitoring of the CoreFLS project were not adequate and the deployment of CoreFLS encountered multiple problems. Even though VA had obligated $249 million of the $472 million budgeted for CoreFLS, it had not been successfully deployed at a VAMC. VA's management of the CoreFLS project did not protect the interest of the Government. We made a number of recommendations to improve contracting procedures, and clinical and administrative controls.

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

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HIGHLIGHTS OF OIG OPERATIONS

This semiannual report highlights the activities and accomplishments of the Department of Veterans Affairs (VA), Office of Inspector General (OIG), for the 6-month period ended September 30, 2004. The following statistical data also highlights OIG activities and accomplishments during the entire fiscal year (FY).

	Current 6 Months 4/1/04 - 9/30/04	FY 2004 10/1/03 - 9/30/04
DOLLAR IMPACT	**Dollars in Millions**	
Funds Put to Better Use	$888.7	$2,828.7
Dollar Recoveries	$4.3	$24.0
Fines, Penalties, Restitutions, and Civil Judgments	$250.2	$258.0
Overpayments and Cost Avoidance Associated with Fugitive Felon	$29.3	$117.1
RETURN ON INVESTMENT		
Dollar Impact ($1,172.5) / Cost of OIG Operations ($32.1)	37:1	
Dollar Impact ($3,227.8) / Cost of OIG Operations ($66.4)		49:1
OTHER IMPACT		
Arrests	356	642
Indictments	236	397
Convictions	174	332
Pretrial Diversions	13	24
Apprehensions	181	330
Administrative Sanctions	262	522
ACTIVITIES		
Reports Issued		
Combined Assessment Program (CAP) Reviews	29	55
Joint Review	1	2
Audits	12	24
Contract Reviews	49	105
Healthcare Inspections	10	26
Administrative Investigations	4	11
Investigative Cases		
Open	483	981
Closed	468	970
Healthcare Inspections Activities		
Clinical Consultations	9	17
Hotline Activities		
Contacts	10,529	24,505
Cases Opened	671	1,217
Cases Closed	610	1,123

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 operations of VA, personnel of the Criminal Investigations Division also frequently find themselves involved in the investigation of violent criminal activity such as murder, armed robbery, narcotic and pharmaceutical trafficking, terrorist or other threats – all of which are occurring on VA property and/or directed at VA personnel, patients, 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.

The Analysis and Oversight Division provides guidance and support for the Office of Investigations by conducting routine office inspections and by directing efforts to identify and develop new initiatives designed to enhance the abilities of investigators to accomplish the core mission in a more effective and efficient manner.

During this semiannual period, the Criminal Investigations Division closed 468 investigations resulting in 423 judicial actions (indictments, convictions, and pretrial diversions) and nearly $302 million recovered or saved. Investigative activities resulted in the arrest of 356 individuals who had committed crimes directed at VA programs and operations or crimes that were committed on VA property. Information developed by our fugitive felon match and provided to other law enforcement agencies resulted in 181 additional arrests of fugitive felons. Criminal investigations also resulted in 216 administrative sanctions. The Administrative Investigations Division closed 12 cases, issuing 4 reports and assisting in a joint Hotline with OIG Offices of Audit and Healthcare Inspections, and 4 advisory memoranda. These investigations resulted in management agreeing to take 14 administrative sanctions, including personnel actions against 10 officials, and corrective actions in 4 situations that will improve VA operations. The Analysis and Oversight Division completed a President's Council on Integrity and Efficiency (PCIE) qualitative assessment review of the investigative operation of another OIG.

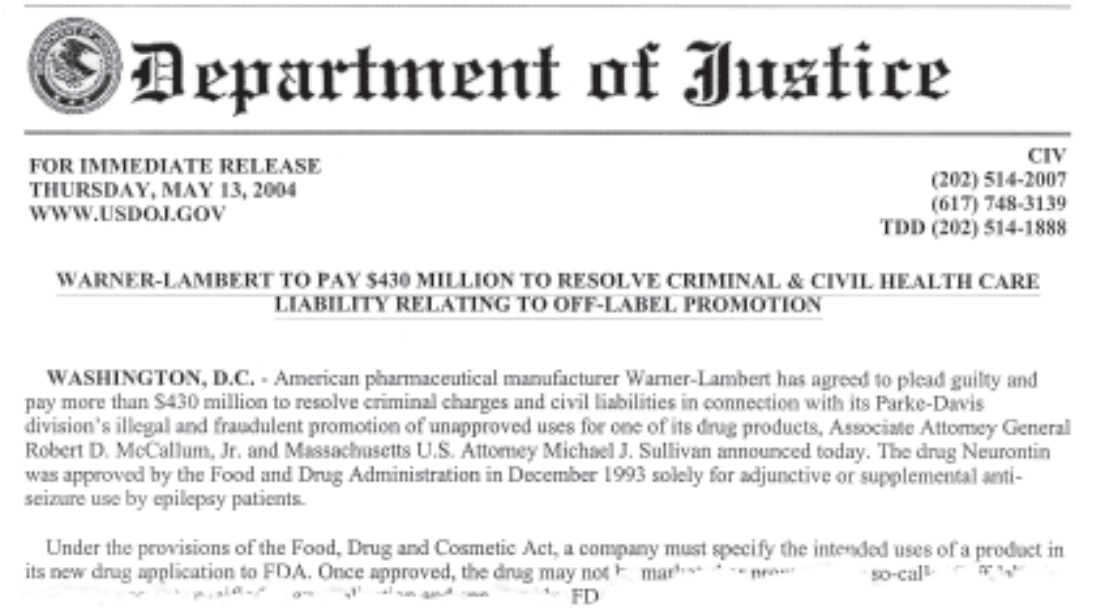
Veterans Health Administration (VHA)

A funeral director was charged with two counts of fraudulent transactions with access devices. The investigation revealed the subject had fraudulently obtained $361,500 by charging VA credit cards for indigent veterans' burial services that had been provided by other mortuary companies.

In a 1996 *qui tam* investigation initiated by the VA OIG, a major pharmaceutical company pled guilty to a two-count criminal information charging the company with a violation of the Food and Drug Administration's (FDA) Food, Drug and Cosmetic Act. The company misbranded Neurontin by: (i) failing to provide

adequate directions for its use, and (ii) introducing an unapproved drug into interstate commerce. This investigation involved the Federal Bureau of Investigation (FBI), the FDA Office of Criminal Investigations, and the Department of Health and Human Services OIG. The vice president of the company appeared in U.S. District Court on behalf of the company and formally entered two guilty pleas. The company was sentenced to pay a $240 million dollar criminal fine and over $190 million dollars in civil liabilities. This sentence is the largest sentence ever imposed in a health care fraud prosecution and the criminal fine is the second largest criminal fine ever imposed in a health care fraud investigation.

Department of Justice News Release
May 13, 2004



Department of Justice

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WARNER-LAMBERT TO PAY $430 MILLION TO RESOLVE CRIMINAL & CIVIL HEALTH CARE LIABILITY RELATING TO OFF-LABEL PROMOTION

WASHINGTON, D.C. - American pharmaceutical manufacturer Warner-Lambert has agreed to plead guilty and pay more than $430 million to resolve criminal charges and civil liabilities in connection with its Parke-Davis division's illegal and fraudulent promotion of unapproved uses for one of its drug products, Associate Attorney General Robert D. McCallum, Jr. and Massachusetts U.S. Attorney Michael J. Sullivan announced today. The drug Neurontin was approved by the Food and Drug Administration in December 1993 solely for adjunctive or supplemental anti-seizure use by epilepsy patients.

Under the provisions of the Food, Drug and Cosmetic Act, a company must specify the intended uses of a product in its new drug application to FDA. Once approved, the drug may not be mar[illegible] so-call[illegible] FD

Veterans Benefits Administration (VBA)

Two individuals pled guilty to charges of conspiracy, mail fraud, and false statements following a joint investigation conducted by the VA OIG, Department of Housing and Urban Development (HUD) OIG, U.S. Postal Inspection Service, and the Internal Revenue Service (IRS). The individuals operated home remodeling businesses and assisted homeowners in obtaining financing for the projects. They submitted false information to banks and lending institutions that qualified homeowners for loans they were otherwise ineligible to receive. The homeowners then failed to make installment loan payments causing several HUD loans and two VA home improvements and structural alterations grants to default. The total loss to the banks, lending institutions, and Government agencies was more than $1.7 million. Both subjects are pending sentencing.

A paralegal, employed by an attorney who was a conservator for ten veterans, pled guilty in Federal court to one count of embezzlement for converting $103,534 of veterans' funds. The subject began embezzling

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Guilty of embezzlement

By JOSH MROZINSKI
Middletown Press Staff

HADDAM — A 30-year-old town resident pleaded guilty on Tuesday to charges of embezzlement and converting $103,534 belonging to the United States, according to the United States Attorney District of Connecticut Office.

HADDAM

Scott Trudel, of 391 Plains Road, entered his guilty plea in the United States District Court in Bridgeport before Judge Janet C. Hall.

Trudel, who will be sentenced on Nov. 30, could face up to 10 years of imprisonment and a fine of $250,000.

As part of the plea agreement, he has agreed to pay back the money he stole.

"He readily admitted his culpability when confronted with the allegations and accusations," said Kevin C. McDonough, Trudel's attorney. "The facts will show there was a gambling addiction here."

Trudel, he said, has sought help for his addiction.

Trudel embezzled the money from the Department of Veterans Affairs and the Social Security Administration through the clients of Gilbride and Rigat, an law firm based in Clinton. He worked at the firm, which acted as a conservator or representative for veterans, as a paralegal in 1999.

Trudebegan embezzling the money in 2002.

He wrote checks payable to veterans and forged their signatures or cashed checks that he wrote from the veteran's accounts that the firm oversaw, according to the Stipulation of Offense Conduct. The stipulation document describes the charges that the defendant and government agree on.

Matthew Gilbride, a partner in Gilbride and Rigat, said he started to look into Trudel's activities after Glenn Formica, an attorney appointed to speak on behalf of one of the veterans, asked him to clarify a line item for one of his clients.

Gilbride said he began investigating the books and eventually looked at the checks, which turned out to be endorsed for cash, or forged, by Trudel.

"Once I started to check the files I saw a pattern," Gilbride said. "When the checks came in I saw right away they were made out for cash."

The authorities were notified and Trudel's employment with the firm was terminated in February, Gilbride said. He said he trusted Gilbride.

"It was disappointing, frustrating and cumbersome," Gilbride said. "He was a good kid, but he made a bad choice."

To contact Josh Mrozinski, call (860) 347-3331, ext. 222 or email jmrozinski@middletownpress.com.

the money in 2002 by writing checks from veterans' accounts, and in many cases forging veterans' signatures, cashing the checks, and taking the money for his personal use. The case was investigated jointly by the VA OIG and Social Security Administration (SSA) OIG.

Fugitive Felon Program

To date, approximately 3.5 million felony warrant files have been received from participating law enforcement agencies. These warrant files were matched to more than 11 million records contained in VA benefit system files, resulting in the identification of more than 38,000 matched records. The records match has resulted in over 12,000 referrals of information from VA files regarding fugitive felons to various law enforcement agencies throughout the country. The information provided to the agencies has directly led to the apprehension of 505 fugitive felons; 294 of these arrests made with the direct assistance of VA OIG agents. Over 9,200 fugitive felons identified in these matches have been referred to the Veterans Benefits Administration (VBA) for benefit suspension resulting in the identification of $57.1 million in overpayments and a cost avoidance of over $119 million.

During this reporting period, there were 181 fugitives apprehended as a result of VA OIG agents directly assisting law enforcement or by sharing our information with law enforcement. There were also 2,671 referrals to VBA for benefit suspension with an identification of overpayments of $10.3 million and an estimated cost avoidance of $19 million.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for $827 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, 91 audits, evaluations, CAP reviews, and contract preaward and postaward reviews were conducted including one joint Hotline with OIG Offices of Investigations and Healthcare Inspections.

A follow-up audit of the Department's WCP found that previous OIG audit recommendations were not fully implemented to enhance the Department's case management and fraud detection efforts and to avoid inappropriate dual benefit payments. As a result, we found opportunities to reduce WCP costs by $696.2 million over the projected lifetime of claimants on the rolls. Also, preaward and postaward contract reviews identified monetary benefits of about $122.6 million resulting from actual or potential contractor overcharges to VA. In addition, CAP reviews identified monetary benefits of $8.2 million.

Veterans Health Administration

The Secretary of Veterans Affairs requested that we determine why the Transitional Pharmacy Benefit program costs and veteran participation were substantially below original estimates. We concluded the program achieved its primary goal of improving access to VA supplied prescription drugs for many veterans who were on lengthy waiting lists for their first primary care appointment. However, the number of veterans eligible for participation and associated costs were significantly less than projected due to changing policies, advanced appointment dates, and stricter eligibility rules.

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 2003 consolidated financial statements, but correction of the conditions was considered necessary for ensuring effective operations.

Multiple Office Action

Our evaluation of VA's Government purchase card program found that improved controls continue to be needed to detect fraud and improper uses of purchase cards.

OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections (OHI) participated with the Offices of Audit and Investigations on 22 CAP reviews of VA medical facilities and reported on specific clinical issues warranting the attention of VA managers. The OHI inspectors reviewed health care issues and made 81 recommendations and 23 suggestions to improve operations, activities, and the care and services provided to patients.

In responding to Congressional and other special requests and reviewing patient allegations pertaining to quality of care issues received by the OIG Hotline, OHI completed 10 Hotline cases, reviewed 54 issues, and made 40 recommendations. These recommendations resulted in managers issuing new and revised procedures, improving services, improving quality of patient care, and making environmental and safety improvements. The OHI assisted the Office of Investigations on nine criminal cases that required extensive review of medical records and quality assurance documents, and monitored the work of VHA's Office of the Medical Inspector.

Nurse Staffing

Inspection of nurse staffing in VHA facilities found managers frequently had to use undesirable practices to provide safe patient care. These practices could have been avoided had VHA developed and implemented procedures to ensure efficient management of nurse staffing resources through the use of consistent staffing methodologies, standards, and data systems; monitored the potential impact of nurse staffing issues on patient care; used effective recruitment and retention strategies; and responded appropriately to issues that influence registered nurse job satisfaction. We made recommendations to improve the management of nursing resources, promote high quality patient care, facilitate nursing recruitment and retention efforts, and enhance nurses' job satisfaction. We also identified $42.4 million in costs that could be better used.

Management of Violent Patients

Inspection of VHA's management of violent patients was conducted to determine the effectiveness of VHA's program to identify violent patients and to minimize the risk to employees, patients, and others visiting VA facilities from threatening and violent patient behaviors. To improve the management of violent patients, VHA needed to establish interdisciplinary response teams trained in violence management in each facility, develop a consistent method of identifying and reporting violent incidents, establish interdisciplinary committees to review and track violent incidents, and implement guidelines for the appropriate use of automated warning flags and ensure that they are applied consistently throughout the system.

Community Residential Care Program

Inspection of the community residential care program found officials needed to review existing policies and ensure all aspects of the guidelines are current, ensure home inspections occur as mandated, provide annual caregiver training, establish a method for monitoring whether VA employees own or operate VA

approved homes, and issue new guidelines requiring caregiver background clearances and statements of agreement whenever patients are referred to assisted living facilities not approved by VA.

Quality Management

Our inspection of VHA facility quality management programs found facility managers needed to strengthen programs through increased attention to the disclosure of adverse events, utilization management, patient complaints program, and medical record documentation reviews. Facility managers needed to strengthen designated employees' data analysis skills and clearly state their expectations to all managers, program coordinators, and committee chairpersons responsible for monitors that corrective actions must be evaluated until resolution is achieved.

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 10,529 contacts and opened 671 cases. Analysts closed 610 cases, of which 207 (34 percent) contained substantiated allegations. The monetary impact resulting from these cases totaled almost $1.1 million. The Hotline staff wrote 102 responses to inquiries received from members of the Senate and House of Representatives. The closed cases led to 32 administrative sanctions against employees and 118 corrective actions taken by management to improve VA operations and activities. Examples of some of the issues addressed by the Hotline include: quality of care, benefits, ethical improprieties, employee misconduct, and Privacy Act and Health Insurance Portability and Accountability Act 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, 2004, there were 54 open OIG reports containing 366 unimplemented recommendations with over $1.98 billion of actual or potential monetary benefits. During this reporting period, we closed 131 reports and 648 recommendations, with a monetary benefit of $915 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 five OIG reports issued over 1 year ago (September 30, 2003, and earlier) with

unimplemented recommendations. Four of these are VHA reports; and one is a VBA report. The OIG is particularly concerned with one report on VBA operations (issued in July 2000) and one report on VHA operations (issued March 2002) 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 Under Secretaries to head the 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),
- Office of Information and Technology,
- Policy, Planning, and Emergency Preparedness (Policy, Planning, and Security and Law Enforcement),

- 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 2004, VA had approximately 218,500 employees and a $62.3 billion budget. There are an estimated 25.2 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 200,000 of VA's employees work in VHA. Health care was funded at over $28.5 billion in FY 2004, approximately 46 percent of VA's budget. VHA provided care to an average of 56,000 inpatients daily. During FY 2004, there were almost 54 million episodes of care for outpatients. VHA operates 158 health care systems and medical centers, 133 nursing home units, 206 veterans centers, 42 VA residential rehabilitation treatment programs (formerly called "domiciliaries"), and 854 outpatient clinics (including hospital clinics). In addition, VHA received over $900 million for capital projects and the state extended care grant program.

Veterans benefits were funded at $32.3 billion in FY 2004, about 52 percent of VA's budget. Approximately 13,000 VBA employees at 57 VA regional offices (VAROs) provided benefits to veterans and their families. Over 2.8 million veterans and their beneficiaries receive compensation benefits valued at $26.3 billion. Also, $3.3 billion in pension benefits are provided to approximately 560,000 veterans and survivors. VA life insurance programs insure 7.7 million individuals for a total of almost $757 billion. Approximately 350,000 home loans were guaranteed in FY 2004, with a value of approximately $47 billion.

The NCA operates and maintains 120 cemeteries and employed about 1,500 staff in FY 2004. Operations of NCA and all of VA's burial benefits account for approximately $430 million of VA's budget. Interments in VA cemeteries continue to increase each year, with 93,000 burials conducted in FY 2004. Approximately 350,000 headstones and markers were provided worldwide for placement in VA and other Federal cemeteries, state veterans' cemeteries, and private cemeteries. NCA also administers the Presidential Memorial Certificate Program and the State Cemetery Grants Program.

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

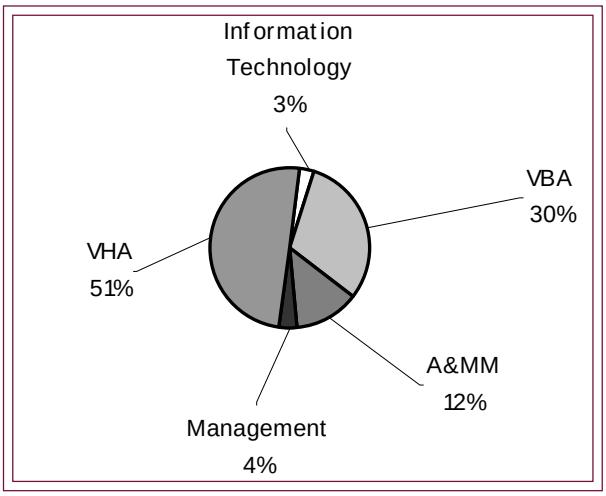
OIG has allocated full-time equivalent (FTE) employees from appropriations as follows.

OFFICE	ALLOCATED FTE
Inspector General	4
Counselor	4
Investigations	140
Audit	177
Management and Administration	59
Healthcare Inspections	48
TOTAL	**432**

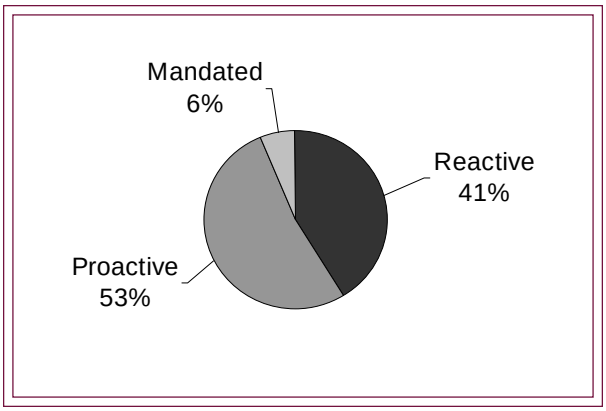
In addition, 25 FTE are reimbursed for a Department contract review function.

The FY 2004 cost of OIG operations was $66.4 million. Approximately 73 percent of the total funding covered salaries and benefits, 4 percent for official travel, and the remaining 23 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.

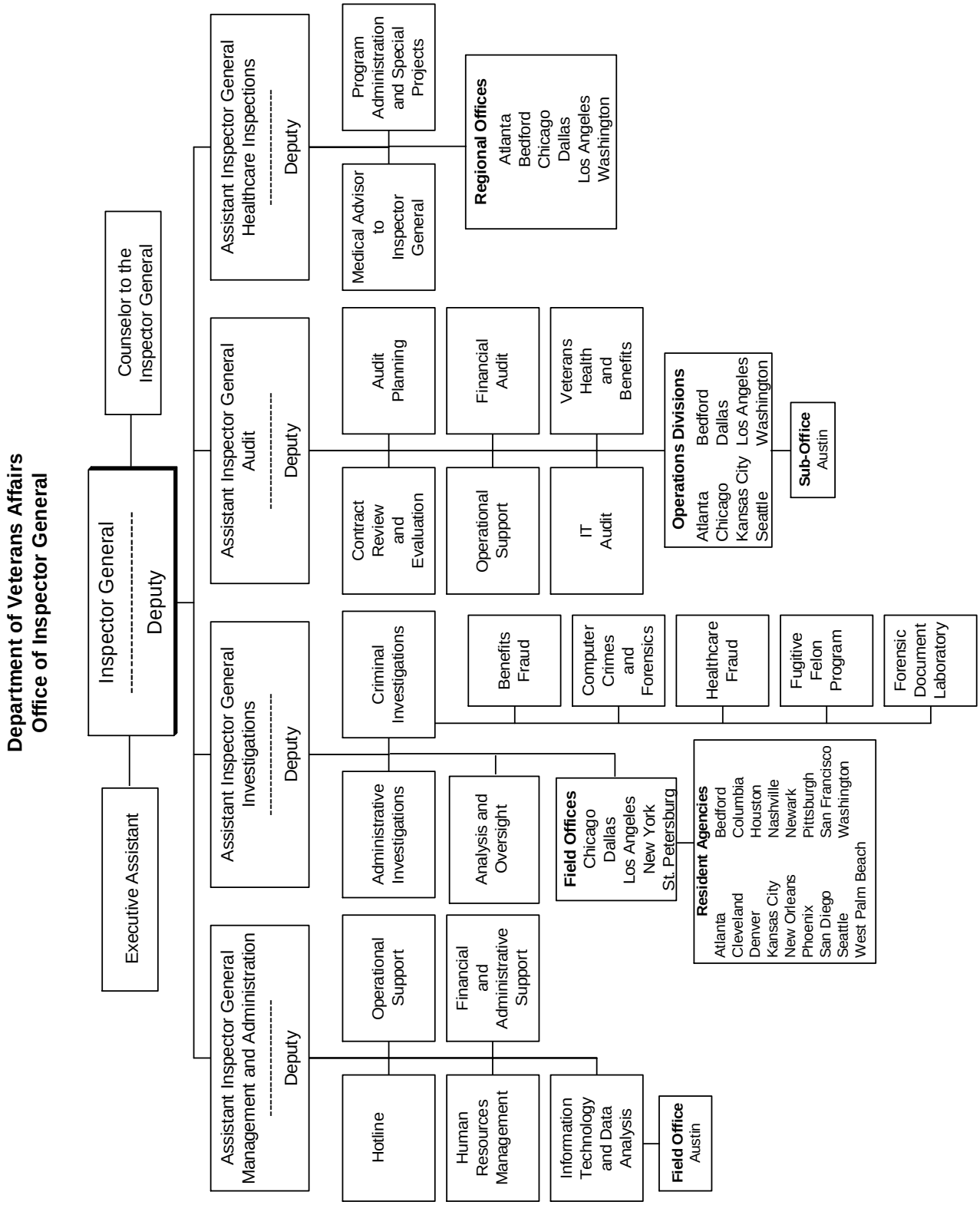
Proactive work is self-initiated, focusing on areas where the OIG staff determines there are significant issues.

OIG Mission Statement

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

In performing its mandated oversight function, the OIG conducts investigations, audits, and health care inspections to promote economy, efficiency, and effectiveness in VA activities, and to detect and deter 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 Healthcare Inspections
Deputy
Program Administration and Special Projects
Medical Advisor to Inspector General
Regional Offices
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Assistant Inspector General Audit
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Audit Planning
Financial Audit
Veterans Health and Benefits
Contract Review and Evaluation
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COMBINED ASSESSMENT PROGRAM

Reports Issued

During the period April 1, 2004, through September 30, 2004, we issued 29 CAP reports with monetary savings of $8.2 million. Of the 29 CAP reports, we reported on 22 VA health care systems (HCS) and VAMCs, and 7 VAROs.

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 HCS and 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 facilities.

Health care 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 efforts include 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 VA 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 22 health care facility CAP reports. See Appendix A for the full titles, report numbers, and dates of the CAP reports issued this period. These 22 reports relate to the following VA medical facilities:

- VAMC Tuscaloosa, Alabama
- Carl T. Hayden VAMC, Phoenix, Arizona
- North Florida/South Georgia Veterans Health System, Gainesville, Florida
- VA Chicago Health Care System, Illinois
- VAMC Togus, Maine
- VA Maryland Health Care System, Baltimore, Maryland
- VAMC Northampton, Leeds, Massachusetts

- VA Ann Arbor Healthcare System, Michigan
- VAMC Battle Creek, Michigan
- Aleda E. Lutz VAMC, Saginaw, Michigan
- VA Gulf Coast Health Care System, Biloxi, Mississippi
- Southern Nevada Healthcare System, Las Vegas, Nevada
- VAMC Bath, New York
- VAMC Northport, New York
- VAMC Chillicothe, Ohio
- VAMC Portland, Oregon
- VAMC Erie, Pennsylvania
- William Jennings Bryan Dorn VAMC, Columbia, South Carolina
- VAMC Memphis, Tennessee
- Amarillo VA Medical Care System, Texas
- El Paso VA Health Care System, Texas
- VAMC Beckley, West Virginia

"The outcomes of this review will assist the medical center in establishing improvement priorities that will certainly enhance the quality of health care being provided to our Nation's veterans. The Medical Center employees shared many positive comments with me regarding the team's overall display of knowledge and the professional manner in which they conducted themselves. Thank you and your team for making the review process a very positive and meaningful experience."

Director, VAMC Memphis

Summary of Findings

Deficiencies identified during prior CAP reviews relating to management of veterans health care programs were discussed in the December 2003 issued OIG report, *Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities October 2002 through September 2003*, and the March 2004 issued OIG report, *Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities October 2003 through December 2003*. During this reporting period, we identified similar problems at the 22 facilities.

Quality Management

- VHA program officials issued clarifications and initiated corrective actions that addressed most of the recommendations made in our previous CAP reports. We noted improvement in facility compliance (94 percent) with holding disclosure discussions with patients who had been injured by adverse events, such as significant medication errors. This result represents a substantial improvement over previous findings. We also noted improvement in patient complaints management.

- The results of our FY 2004 CAP reviews found facility managers could improve their utilization management programs. Our reviews showed managers were uncertain of VHA's expectations for conducting utilization management reviews. We found most facility managers consistently reviewed acute care admissions and the reasons for continued stay days against established criteria (e.g., severity of illnesses and intensity of service). However, we found that 6 of 17 facilities did not meet established goals for appropriate admissions, and 9 of 17 facilities did not meet goals for continued stay days.

- Our reviews also showed improvement is still needed in data management across many areas, such as aggregated patient safety, outcomes of

resuscitation, and staffing effectiveness. Facility managers did not consistently benchmark their results, identify specific corrective actions, define evaluation criteria, or implement and evaluate corrective actions. We found some significant quality management actions did not succeed because existing tracking systems did not assure full implementation.

- Senior facility managers needed to continue efforts to increase their visibility by visiting clinical areas more frequently. While most facility managers stated they visited clinical areas of their facilities at least monthly, others expressed regret that network and national demands limited their ability to visit patient care areas more frequently.

Procurement

The OIG identified 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, contract award actions, and contract administration; and (iii) strengthen inventory management.

- Government purchase card controls were deficient at 9 of 19 facilities where we tested these issues. Policies and procedures governing the administration of the purchase card program, segregation of duties, timeliness of payments, use of purchase cards, purchasing limits, and accounting for purchases.

- Service contract controls were deficient at all 7 facilities where we tested these issues. Contract award and administration deficiencies were identified at 13 of 15 facilities where we tested these issues. Controls needed to be strengthened to ensure that: (i) Acquisition and Materiel Management Service staff follow preaward and postaward contract policies and procedures, (ii) contract provisions include procedures to help ensure contract compliance, (iii) contracting officials properly monitor contract performance and payment for services, and (iv) contract files include all required documentation.

- Management of medical supply inventory was deficient at 15 of 18 facilities and nonmedical inventory management was deficient at 13 of 15 facilities where we tested these issues. We found that supply inventories were either not performed or inaccurate, and inventory levels exceeded current requirements resulting in funds being tied up unnecessarily in excess inventories. The Generic Inventory Package database needed to be implemented in accordance with VA policy to improve supply inventory management, and periodic physical inventory counts performed to verify actual quantities on hand. Also, management of equipment inventories was deficient at 7 of 8 facilities where we tested these issues.

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 2003 Federal Information Security Management Act audit, which identified information security vulnerabilities that place the Department at risk of: (i) disruption and denial of service attacks on mission critical systems, (ii) unauthorized access to and improper disclosure of data subject to Privacy Act protection and sensitive financial data, and (iii) fraudulent receipt of health care benefits.

- Information technology (IT) security deficiencies were found at 15 of 22 facilities. We found that: (i) security plans were not prepared or not kept current and lacked key elements, (ii) review of access to automated information systems was not performed quarterly, (iii) access to VHA's Veterans Health Information Systems and Technology Architecture was not effectively monitored, (iv) background investigations were not conducted on contract personnel working in sensitive areas, and (v) annual security awareness training was not conducted.

Controlled Substances

- VA has established policies, procedures, and guidelines for accountability of controlled substances and other drugs. However, controlled substance inspection procedures had some deviation from VHA policies at 17 of 21 facilities where we tested these issues. 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. Also, suspected thefts, diversions, or suspicious losses of controlled substances were not reported to the OIG Office of Investigations. 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 health care facilities continue to increase Medical Care Collection Fund collections. However, we found deficiencies at 11 of 17 facilities where we tested these issues. Facility management needs to strengthen billing procedures to avoid missed billing opportunities, improve timeliness of billings, and improve accuracy of diagnostic and procedure coding. Also, facilities need to adequately document services provided to patients in their medical records to justify billings.

Pharmacy Security

- VA health care facilities need to improve physical security in pharmacy areas to meet VA standards. We found physical security deficiencies in pharmacy areas at 5 of 11 facilities where we tested these issues.

Part-Time Physician Time and Attendance

- VA health care management did not have effective controls in place to ensure that part-time physicians were on duty when required by employment agreements at 6 of 13 facilities where we tested these issues. One of the facilities did not have written part-time physician time and attendance agreements. 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.

Financial Controls

- Controls over the agent cashier function needed improvement at 3 of 6 facilities where we tested these issues. Unannounced audits were not conducted timely, cash counts of cashiers' cash boxes were not conducted, and separation of duties was not maintained.

- Controls over accounts receivable needed improvement at 4 of 12 facilities where we tested these issues. Fiscal Service needed to aggressively pursue accounts receivable for collection, timely record accounts receivable actions, reconcile accounts receivable with individual accounts monthly, and follow up on decisions regarding requests of waivers for suspended employees' accounts receivable.

- Personal funds of patients' accounts controls needed improvement at 3 of 5 facilities where we tested these issues. At one site, staff did not maintain documentation to support that disbursement of deceased patient funds were made to the proper beneficiaries or that patient beneficiaries had been properly notified of the disbursement. At another site, patient competency status was not documented to allow clerks to determine if a patient's account was restricted or unrestricted.

Moderate Sedation

- We reviewed local policies, employee training records, practitioner clinical privileges, patient medical records, and inspected areas where moderate sedation was provided outside of the operating room. We identified opportunities for improvement in 7 of 9 facilities. Employees had not completed required training, including cardiopulmonary resuscitation in 3 of 7 facilities, and one physician did not have clinical privileges to perform moderate sedation. Clinicians needed to complete patient physical assessments prior to procedures in 4 of 7 facilities. Adverse event reporting processes and patient monitoring needed strengthening in 2 of 7 facilities to improve patient safety.

Bulk Oxygen Utility System

- Controls over bulk oxygen utility systems needed improvement at 3 VHA sites tested. On April 5, 2004, VHA issued a patient safety alert to all VISNs addressing the oxygen utility system failures at two VAMCs. The patient safety alert directed VISN managers to initiate appropriate actions to ensure their medical centers' oxygen utility systems were secure and in compliance with the National Acquisition Center oxygen contract requirements. These actions were to be completed by April 30, 2004. We found that 2 of 3 facilities had not developed plans to supervise bulk oxygen delivery, and 2 of 3 facilities had not forwarded a copy of the mutual agreement developed between the facility contracting officer's technical representative and the local vendor to the center as required.

Conflict of Interest Acknowledgment

- VA health care facility management needed to improve controls at 2 of 5 facilities visited to ensure that physicians, clinicians, and allied health supervisors or managers sign copies of the conflict of interest acknowledgment form in accordance with VA policy.

Survey Results

Outpatient Surveys

We surveyed 452 VA outpatients at 19 facilities to ascertain their satisfaction with the care. We interviewed patients in primary care, mental health, and specialty care clinics. We also surveyed outpatients who were in waiting areas of the various supportive services such as pharmacy, radiology, and laboratory.

- Overall, 92 percent of the outpatients rated the quality of care as good, very good, or excellent. Ninety-three percent of the respondents stated that they would recommend medical care to eligible family members or friends, and 91 percent told us their treatment needs were being addressed to their satisfaction.

- Eighty-nine percent of the outpatients told us they felt involved in decisions about their care, 82 percent told us a health care provider discussed the results of tests and procedures with them, 96 percent told us their primary care provider discussed the reasons for medications with them, 88 percent were told the reasons for referrals to specialist, and 94 percent were told why diagnostic tests were ordered.

Tuscaloosa VA Medical Center
Tuscaloosa, AL

- Only 71 percent of the outpatients told us they were generally able to schedule appointments with their primary care providers within 7 days of their request, and only 68 percent of the outpatients who were referred to a specialist told us they were given appointments and were assessed by the specialist within 30 days of the referrals.

- Seventy-four percent of the outpatients stated they received counseling by the pharmacist when they received new prescriptions and 85 percent said they received their refills in the mail before they ran out of their medications. Only 60 percent of the outpatients told us they received their prescriptions from the outpatient pharmacy within 30 minutes.

Physical Plant Environment

We conducted environment of care inspections in 20 facilities evaluating primary care and specialty outpatient clinics, inpatient wards, emergency rooms, intensive care/coronary care units, nursing home care units, domiciliary units, psychiatry units, surgery, rehabilitation areas, and some kitchens and canteens.

- Overall, we found most facilities were generally clean and well maintained with minor issues management corrected immediately during our inspections. Seven facilities received recommendations for safety, infection control, or cleanliness violations. Safety issues were identified as the predominant environmental issue. A trend was noted regarding unsecured items such as medications, chemicals, and supplies. Management also needed to address damaged handrails, suicide risk prevention in locked mental health units, emergency evacuation procedures, and patient privacy and confidentiality. Most cleanliness issues had to do with general housekeeping and maintenance.

Employee Surveys

Employee feedback was obtained from responses to a Web-based survey we implemented at 21 CAP reviews. All employees of each facility were notified by e-mail about the survey and were provided with the Web address. We received 2,803 responses. Since we began performing CAP reviews, we have systematically elicited employees' perceptions on a wide range of issues. We believe the resulting data can provide an independent, objective indicator of employee satisfaction for facility management to use in decision-making. VHA aspires to be the employer of choice. In 1997, VA administered the "One VA" survey, but did not follow-up with annual surveys. In the absence of this source of employee feedback, we provided facility management with survey results obtained during CAP reviews.

- Seventy-nine percent of the employees who responded felt quality patient care was the first priority at their medical center. Eighty-three percent of the respondents believed that the quality of care provided to patients at their respective facilities was either good or excellent. Over 83 percent of the employees who responded felt that their medical center was clean, and 70 percent of them asserted that they would recommend their facility to an eligible family member or friend.

- More than 83 percent of the respondents believed that they received proper orientation, education, and training to do their jobs. In addition, 62 percent of these employees felt management provided them opportunities to fulfill their continuing education needs or requirements. Seventy-seven percent of the employees who responded asserted that adequate supplies were available for them to do their jobs.

We noted the following deficiencies that were common to many of the facilities:

- Forty-nine percent of the responding employees believed that they had not been offered opportunities for career advancement.

- More than 32 percent of respondents asserted work orders for needed repairs were not addressed promptly at their facilities.

- Only 44 percent of responding employees felt staffing levels were usually sufficient to provide safe patient care.

Combined Assessment Program Overview - Benefits

During this period, we issued seven CAP reports on the delivery of benefits. See Appendix A for the exact titles, report numbers, and dates of the CAP reports issued. These seven reports relate to the following benefit facilities:

- VARO Detroit, Michigan
- VARO Jackson, Mississippi
- VARO Lincoln, Nebraska
- VARO Albuquerque, New Mexico
- VARO Winston-Salem, North Carolina
- VARO Salt Lake City, Utah
- VARO Seattle, Washington

Summary of Findings

Deficiencies identified during prior CAP reviews in the management of veterans benefits programs were discussed in the January 2004 issued OIG report, *Summary Report of Combined Assessment Program Reviews at Veterans Benefits Administration Regional Offices October 2002 through September 2003.* During this reporting period, we identified similar problems at all seven facilities.

Compensation and Pension Claims Processing

- Compensation and pension benefits for veterans hospitalized for extended periods of time at Government expense were not reduced as required at each of the seven facilities. Veterans Service Centers did not always identify hospitalized veterans whose benefits required adjusting. Management should ensure that payments to certain veterans be reduced as appropriate, consult with medical center staff to improve compliance with requirements for notification when veterans are hospitalized for extended periods, and provide refresher claims processing training for Veteran Service Center staff.

Information Technology

- IT security was deficient at 3 of 7 facilities. The CAP review coverage of VBA facilities in FY 2004 identified a wide range of vulnerabilities in VBA systems similar to those we identified during VHA CAP reviews. These deficiencies could lead to misuse or loss of sensitive automated information and data. The CAP review findings show a need to improve access controls and contingency planning.

VA Regional Office
Jackson, MS

Sensitive Records Security

- Physical security controls over sensitive records needed improvement at 4 of 7 facilities. Semiannual reviews of hardcopy and electronic file security were not performed as required, access to file cabinets containing employee-veteran claims folders and other sensitive records were not properly controlled, sensitive files were not secured in locked files, claims folders were not maintained at the designated regional offices of jurisdiction, and sensitive electronic records were not secured through the common security user manager application. Inadequate controls increase the risk of employee-veteran alteration of compensation and pension benefits, unauthorized access to private information, and may create the appearance of staff bias towards processing employee claims. Management needs to ensure that required sensitive records reviews are conducted and documented, sensitive records are transferred and maintained at the designated office of jurisdiction, sensitive records are secured in locked files, and electronic records are secured through the common security user manager.

Other VBA Programs

- VBA's processing and timeliness over vocational rehabilitation and employment claims continues to need improvement. Data entry, claims processing, and case monitoring errors were noted at all seven facilities. Management needs to ensure that processing of claims for vocational rehabilitation benefits is timely, data is entered accurately, and claims status is monitored. Appropriate actions are needed to promptly place veterans who are not pursuing their approved training programs in the discontinued status, or if veterans have completed the program, place them in a rehabilitated status.

- We found that improvements at 4 of 7 facilities were needed in fiduciary and field examination controls and procedures. Fiduciary and field examination accountings were not always submitted timely or accurately. Management needed to improve the oversight of incompetent veterans by ensuring accountings and field examinations were conducted timely, accurately documented, and that appropriate corrective actions were taken.

- Government purchase card program deficiencies existed at 3 of 7 facilities. Reconciliations and certifications were not performed timely, single purchase limits were not enforced, and purchase card actions lacked adequate separation of duties. Management needed to ensure that dates of monthly purchase card reconciliations and certifications were recorded, unwarranted cardholders did not exceed their $2,500 micro-purchase limit, and separation of duties were enforced or explain why the facility can not meet the requirement and document the reasoning for their modified policy on separation of duties.

- Benefits delivery network system-generated messages were not processed timely or properly at 2 of 6 facilities where we tested the system. This resulted in our identification of both overpayments and underpayments of veterans' benefits.

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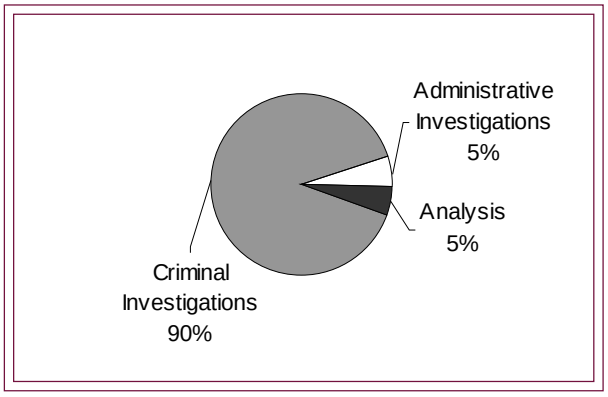
OFFICE OF INVESTIGATIONS

Mission Statement

Conduct investigations of criminal activities and administrative matters relating to the programs and operations of VA in an independent and objective manner and seek prosecution, administrative action, and/or monetary recoveries in promoting integrity, efficiency, and accountability within the Department.

Resources

Overall, the Office of Investigations has 140 FTE allocated to its three divisions: Criminal Investigations Division, Administrative Investigations Division, the Analysis and Oversight Division, and senior management. The following chart shows the allocation of resources.

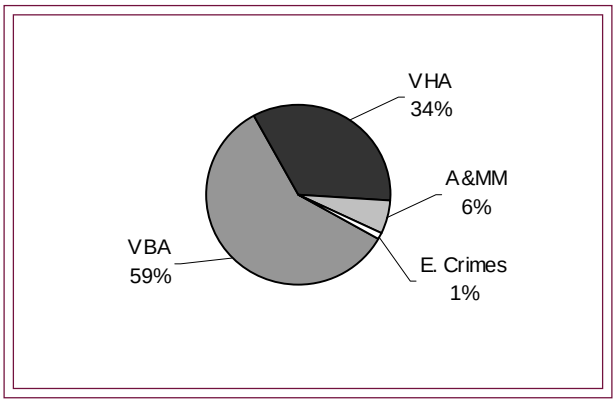


I. CRIMINAL INVESTIGATIONS DIVISION

This 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 or state and local officials for prosecution. The Division is also responsible for operation of both the Questioned Document Forensic Laboratory and the Computer Crimes Forensic Laboratory.

Resources

The Criminal Investigations Division has 124 FTE allocated for its headquarters and 22 field locations. These individuals are deployed in the following VA program areas.



Overall Performance

Output

- 468 investigations were concluded during the reporting period.

Outcomes

- Arrests – 356
- Indictments – 236
- Convictions – 174
- Pretrial Diversions – 13
- Fugitive Felon Apprehensions – 181*
- Administrative Sanctions – 216
- Monetary benefits – $301.9 million ($250.2 million – fines, penalties, restitutions, and civil judgments; $19.8 million – efficiencies/funds put to better use; $2.6 million – recoveries; and $29.3 million – overpayments and cost avoidance created by VBA related to fugitive felon match)

* This includes the apprehension of 99 fugitive felons by VA OIG, and 82 apprehensions made by other law enforcement entities as a result of information provided by the VA OIG fugitive felon program.

Customer Satisfaction

Customer satisfaction during this reporting period was 4.9 on a scale of 5.0.

Veterans Health Administration

The Criminal Investigations Division investigates those instances of criminal activity against VHA that have the greatest impact and deterrent value, including crimes such as patient abuse, theft of Government property, drug diversion, bribery/kickback activities by employees and contractors, false billings, and inferior products. 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.

Drug Diversion

- An individual was sentenced to 12 months' imprisonment after pleading guilty to charges of theft of Government property. A joint VA OIG, FBI, and VA police investigation revealed the individual entered a VAMC pharmacy under the pretext of a student conducting research and stole 298 oxycodone tablets and 83 morphine sulfate tablets from a controlled narcotics cage inside the pharmacy. Additionally, the individual took a bottle of methaldolpa from the general area in the pharmacy.

Distribution of Controlled Substances

- A VA nurse was indicted for distributing fentanyl, a controlled substance, after an investigation determined the nurse provided this synthetic form of morphine to a co-worker who subsequently died due to a lethal dose of the drug. The nurse confessed to providing the fentanyl to her co-worker the day prior to his death. She also admitted to tampering with evidence at the crime scene.

- A defendant was sentenced to14 years' imprisonment after pleading guilty to aiding and abetting the distribution of cocaine base within 1,000 feet of a playground. A second defendant

was also sentenced to 30 years' imprisonment for conspiracy to distribute controlled substances in excess of 50 grams, possession with intent to distribute cocaine base, and possessing the drug within 1,000 feet of a playground. These two defendants were part of a group of 17 individuals, including VAMC workers and patients, investigated by the VA OIG, the Drug Enforcement Administration, and a local drug task force.

- The VA OIG and VA police arrested a VA employee for the distribution of a controlled substance at a VAMC. The housekeeping aide was caught selling two grams of cocaine to another VA employee and later confessed to distributing cocaine and marijuana to several VA employees in exchange for cash and OxyContin.

Health Care Fraud

- A former employee of a VAMC was sentenced to 30 months' imprisonment, 5 years' probation, and ordered to pay $718,000 in restitution stemming from convictions of the former employee and her daughter on charges of conspiracy, theft in connection with health care, mail fraud, and wire fraud. A joint investigation with the FBI revealed that, from July 2002 until September 2003, the pair stole and negotiated $718,000 in medical reimbursement checks received by the medical center where the mother was employed. Additionally, the daughter, who had previously been sentenced, defrauded a bank of $69,500.

Employee Theft

- A former VAMC nursing assistant was sentenced to 30 days' imprisonment, 3 months' home detention, 5 years' probation, and ordered to pay $12,000 in restitution for stealing, forging, and negotiating blank personal checks belonging to former VAMC nursing home patients.

- A VA nurse's aide and her boyfriend were arraigned for stealing the credit card of a VAMC inpatient and fraudulently using the card. The investigation disclosed that after the fraudulent use, the nurse's aide returned the credit card to the patient's room in an attempt to go undetected. This was a joint investigation by VA OIG and VA police.

- Criminal charges were filed against a former VA nurse charging her with theft for stealing credit cards belonging to three patients at a VAMC. A VA OIG investigation determined the nurse used the stolen credit cards to make purchases at local businesses.

Environmental Violations/ Employee Misconduct

- Four VA employees, two contractor employees, and two contractor companies were charged with four felony counts of violating state environmental protection laws. The subjects were charged with the unlawful disposal of hazardous waste, the deposit of a hazardous substance, and the discharge of a pollutant. An investigation determined there had been mishandling of copper sulfate, a Federal and state regulated hazardous substance, which was a generated by-product of water treatment at a VAMC.

Procurement Fraud/Bribery

- A plumbing supervisor employed at a VAMC was sentenced to 27 months' incarceration, followed by 3 years' supervised release, and ordered to pay $79,711 in restitution after pleading guilty to charges of bribery and

conspiracy. A former VA contractor was also sentenced to 3 years' probation. An investigation revealed the employee and a plumbing supervisor at a VAMC engaged in a scheme to inflate and falsify purchase orders for emergency and routine plumbing repairs. The employee, aided by the contractor, overcharged the VAMC more than $80,000 during a 3-year period.

- The corporate president of a former VA general contracting company, as well as the company itself, were indicted for conspiracy, false statements, and false claims after an investigation disclosed that foreign steel was supplied to the VA general contractor in violation of the "Buy American" requirement of all Federal construction contracts. The true source of the steel was concealed from VA and used in an expansion project at a VAMC. The corporation, through the president, pled guilty and is pending sentence. The owner of a steel fabrication business used by this general contractor entered a guilty plea and is pending sentence after admitting her role in the criminal conspiracy.

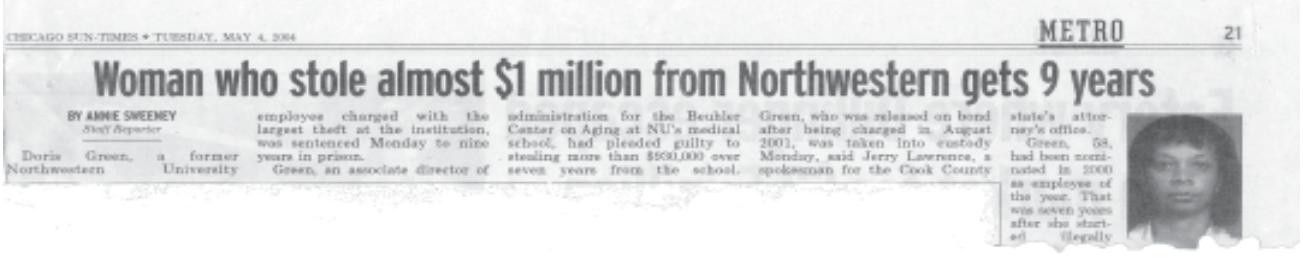
- Following an indictment on charges of procurement fraud, a recently retired senior VA chaplain was placed on pre-trial diversion and ordered to pay $20,000 in restitution. A VA OIG investigation revealed the chaplain and a co-conspirator entered into a contractual agreement with VA to provide community-based residential care, treatment, and rehabilitative services for homeless veterans. However, veterans were frequently not fed while the pair diverted funds for their own uses. The chaplain's co-conspirator has also been indicted.

- A VA contractor's consultant was sentenced to 5 years' probation for his role in frauds he and his VA contractor co-conspirator committed while operating the VA contractor's business. The court also ordered the consultant to begin paying the $500,000 fine that was part of his plea agreement. The consultant and his co-conspirator were 2 of 3 people convicted in this investigation involving a conspiracy to defraud bonding companies, financial institutions, and numerous contract owners, including Federal and municipal agencies, by defaulting on multiple contracts.

Embezzlement

- An individual was sentenced to serve 9 years' imprisonment after pleading guilty to one count each of theft and computer fraud. An investigation revealed the individual was previously employed by a university medical center, which was affiliated with a VAMC and a consortium of other local health care facilities. Over a 7-year period, the individual embezzled $931,497 from consortium members, including the VAMC.

Chicago Sun-Times, Chicago, IL — Tuesday, May 4, 2004



CHICAGO SUN-TIMES • TUESDAY, MAY 4, 2004 METRO 21

Woman who stole almost $1 million from Northwestern gets 9 years

BY ANNIE SWEENEY
Staff Reporter

Doris Green, a former Northwestern University employee charged with the largest theft at the institution, was sentenced Monday to nine years in prison.

Green, an associate director of administration for the Beuhler Center on Aging at NU's medical school, had pleaded guilty to stealing more than $930,000 over seven years from the school.

Green, who was released on bond after being charged in August 2003, was taken into custody Monday, said Jerry Lawrence, a spokesman for the Cook County state's attorney's office.

Green, 58, had been nominated in 2000 as employee of the year. That was seven years after she started illegally

Extortion

- In a joint investigation conducted by VA OIG and the FBI, the director of a consolidated mail out pharmacy (CMOP) and a Government contractor who worked at the CMOP were arrested. The two men were charged with soliciting a bribe in a scheme to extort money from an employee-leasing company with a contract to supply workers to the CMOP.

Possession of Child Pornography

- A former VA employee was sentenced to 60 months in jail after he was found guilty on two counts of possession of child pornography. A VA OIG investigation revealed that the employee accessed child pornography sites while working at a VAMC.

Identity Theft

- After pleading guilty to illegal possession of an identification document with intent to defraud the Government, an individual was sentenced to 12 months' imprisonment, 12 months' supervised probation, and ordered to pay $13,410 in restitution. Dating back to 1998, the defendant had used a veteran's identity in several criminal schemes, which included obtaining treatment at various VAMCs.

- A dishonorably discharged veteran, who assumed the identity of another veteran, was sentenced to 21 months' imprisonment, 36 months' probation, and ordered to pay $92,852 in restitution after pleading guilty to mail fraud charges. A joint investigation by the VA OIG, U.S. Postal Inspection Service, and a local police department disclosed that the subject was admitted to a VA hospital and obtained over $50,000 of health care benefits using the other veteran's identity. While an inpatient at the VA hospital, the subject fraudulently applied for and received VA pension benefits subsequent to his release from the hospital. A public guardian for the legitimate veteran discovered the scheme and reported it to local law enforcement.

Threats

- A veteran was arrested based on charges of making criminal threats. The veteran became enraged during a medical appointment at a VAMC and threatened to kill the doctor and other staff who were present. The veteran further threatened to return to the VAMC to kill everyone. The veteran was incarcerated on unrelated armed robbery charges at the time of the arrest. The veteran has a violent criminal history, including sex offenses against children.

- A veteran, previously charged with making a false bomb report, was sentenced to 30 days' incarceration, 30 days' home confinement, ordered to serve 30 days' community service, 2 years' probation, and to attend anger management classes. After receiving a report from local police that an individual called 911 and made a bomb threat naming the VAMC as the target, a VA OIG investigation was initiated and identified the veteran as the caller.

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 of their homes, and educational benefits are obtained under false representations. The Office of Investigations spends considerable resources in investigating and arresting those who defraud operations of VBA.

Daily Southtown
Tinley Park, IL
Wednesday, July 14, 2004

Woman cashed in on dead great-grandpa

Fraudulently collected survivor's benefits

By Chris Hack
Staff writer

A former Harvey woman admitted Tuesday she continued to collect military veterans compensation for her great-grandfather more than a decade after he died.

Felicia C. Smith, 33, pleaded guilty to a single federal count of wire fraud. Smith, a married mother of two, now lives in Texas.

She faces up to five years in prison when sentenced Oct. 13.

Prosecutors said Smith's great-grandfather, who served in the military during World War II, collected federal Veterans Administration payments for a disabling combat injury.

After he died in 1989, his wife started having veterans survivor benefit money electronically deposited each month into her account at a Harvey bank.

But shortly after the great-grandmother died in 1995, Smith took over the bank account and started spending the monthly deposits. And in 1998, when the VA sent paperwork to the great-grandmother, Smith forged the dead woman's signature and sent the documents back to ensure the payments continued.

Smith fraudulently collected more than $36,000 in the scam between 1998 and 2001. But she could be ordered to pay nearly twice that in restitution, which may include the money she collected before the forgery, Assistant U.S. Attorney Timothy Chapman said.

Chris Hack may be reached at chack@dailysouthtown.com or (708) 633-5984.

Death Match Project

- The Office of Investigations is conducting an ongoing proactive project in coordination with the VA OIG Information Technology and Data Analysis Division. The death match project 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 5,800 leads have been reviewed, resulting in the development of 775 criminal and administrative cases. Investigations have resulted in the actual recovery of $11.7 million, with an additional $7.8 million in anticipated recoveries. The 5-year projected cost avoidance to VA is estimated at $27.6 million. To date, there have been 109 arrests in these cases with several additional cases awaiting judicial actions.

Bank Fraud

- The great-granddaughter of a deceased VA dependency and indemnity compensation (DIC) recipient pled guilty to an indictment charging her with one count of wire fraud. A VA OIG investigation using information developed by the death match project revealed that, over a period of 5 years, the defendant used $64,000 in VA funds intended for her great-grandmother for her personal benefit.

- A husband and wife were arrested on charges stemming from a VA OIG investigation involving theft of DIC benefits. The husband and wife, who were caretakers for a DIC beneficiary prior to her death in June 1992, continued to use the deceased beneficiary's DIC benefits for personal gain. The loss to VA was $146,247.

- The nephew of a deceased VA beneficiary was sentenced to 12 months' imprisonment, followed by 36 months' probation, and ordered to pay $142,532 in restitution after pleading guilty to wire fraud. A joint investigation by VA OIG and the SSA OIG disclosed the nephew continued to receive his deceased aunt's VA DIC benefit checks by mail along with her SSA benefit checks. The nephew later changed the VA and SSA benefits to direct deposit into his deceased aunt's account, to which he had access. The loss to VA was $101,063.

- After pleading guilty to a two-count indictment charging false claims and making materially false representations, a veteran was sentenced to 37 months in prison and ordered to pay restitution to VA. A VA OIG investigation revealed the veteran had fraudulently 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 compensation for special adaptive housing and assistance in purchasing an automobile. Investigation disclosed he could walk without the aid of assisting devices. The loss to the VA was $384,934.

- A veteran was sentenced to two counts of wire fraud after he falsely claimed and received benefits for 10 children, when, in reality, he only had one eligible dependent. The VA loss was $17,454. In addition, the veteran defrauded numerous September 11 charities for almost $104,000 and tried to receive an additional $76,000, claiming his wife had been killed at the World Trade Center. The veteran was sentenced to 41 months' confinement and ordered to pay $136,000 in restitution.

- The son of a deceased widow pled guilty to one count of theft of Government funds. The beneficiary died in November 1993 and the son subsequently converted the VA benefits to his own use. The loss to VA was $106,479.

Equity Skimming

- After being convicted of mail fraud and equity skimming in connection with real estate scams, a subject was sentenced to 18 months' imprisonment, followed by 5 years' supervised release. He was also ordered to pay restitution of $351,102, a fine of $20,000, and court costs.

Fiduciary Fraud

- A court appointed guardian was indicted on multiple counts of misapplication of fiduciary funds. A joint investigation with a state law enforcement agency disclosed that from 1999 to 2003, the guardian, acting as a court appointed financial guardian for his veteran father, misappropriated $116,000 from his father's estate. These funds included both Social Security and VA disability payments.

- A paralegal, employed by an attorney who was a conservator for 10 veterans, pled guilty to embezzlement of $103,534. The subject began embezzling the money in 2002 by writing checks from the veterans' accounts, and in many cases forging their signatures, cashing the checks, and taking the money for his personal use. In keeping with the conservator's responsibilities, the attorney made the veterans' accounts whole, resulting in an administrative recovery of $103,534.

Identity Theft

- An individual was arrested after an investigation revealed he had allegedly used a deceased veteran's DD Form 214 and other documents in order to assume the identity of the

deceased veteran for the purpose of fraudulently filing for VA benefits. In addition, the individual allegedly altered the same DD Form 214 with his own name so that he could receive VA benefits even though he never served in the armed forces. At the time of his arrest, the individual was receiving pension benefits under the name of the deceased veteran and his own. The loss to VA was $112,000.

- The brother of a veteran pled guilty to four counts of mail fraud. The subject used the identity of his brother, a Vietnam-era veteran, to obtain service-connected compensation and medical benefits beginning in 1991. The brother fraudulently received VA compensation benefits totaling $266,381 and VA medical benefits totaling $33,791.

Office of Workers' Compensation Programs (WCP) Fraud

- A veteran, an employee of the U.S. Postal Service who was receiving WCP benefits, was indicted and subsequently arrested on charges of mail fraud, WCP benefit fraud, and making false statements. Investigation revealed the defendant was self-employed and operated his own medical equipment company. Additionally, he was fraudulently receiving disability benefit compensation from VA for stress, trauma, and physical abuse that he falsely claimed to have suffered at the hands of the Iraqi military as a prisoner of war during Desert Storm in 1991. Loss to the Government for disability payments exceeded $200,000.

- A former VA employee, who was receiving WCP benefits from 1970 through 2000, was sentenced to 24 months' probation and ordered to pay $75,000 in restitution. The defendant was previously found guilty of making false claims involving these benefits while owning and operating a counseling service that contracted with various state and local Government agencies for the last 9 years. A separate administrative action against the defendant by the Department of Labor resulted in a recovery order of $174,875.

Theft and Forgery of VA Benefit Checks

- A subject was arrested and charged with money laundering. The arrest was the culmination of an investigation by the U.S. Secret Service, Railroad Retirement Board (Railroad), IRS, SSA OIG, and VA OIG. From about October 1999 to April 2000, the subject and three other defendants participated in a scheme to intercept in excess of 3,000 U.S. Treasury benefit checks intended for VA, SSA, and Railroad pensioners living in Mexico. These checks were intercepted in Mexico City, which is the central distribution point for all pensioners living within Mexico. The checks were then sent via courier to a business in the United States that was owned and operated by the subject's family, where the checks were forged and then negotiated through the business accounts. Loss to VA and other Federal agencies was in excess of $3.5 million.

Education Fraud

- Two officials of a technical institute were indicted for wire fraud and false statements after a joint investigation with the Department of Education OIG disclosed that the officials falsely certified the technical institute with a state approving agency as a branch of an approved college with which it was affiliated. This resulted in the financial aid office of the college certifying to VA the enrollment of veterans as if they were enrolled in an approved college. Based on the erroneous enrollment certifications, VA made

educational benefit payments of $17,115 to veterans.

Attempted Bribery

- The owner/president of a local college was sentenced to 3 months' imprisonment and was fined $5,000 following his conviction on bribery and conspiracy charges. An investigation disclosed the college president paid bribes to an undercover VA OIG special agent in return for having veterans referred to his college as students. This investigation and subsequent judicial proceedings led the subject to resign as president of the college.

Loan Guaranty Fraud

- The general manager of a mortgage company pled guilty to conspiracy and false statements after a joint agency investigation with HUD OIG revealed that employees of the mortgage company had defrauded several Federally insured financial institutions by submitting forged mortgages as collateral on their warehouse lines of credit loans. The investigation revealed that the employees submitted a series of false documents in order to obtain HUD and VA guarantees on the mortgage loans. The defendants also concealed information from auditors and thereafter submitted fraudulent audit reports to the Federal Housing Administration (FHA) in order to conceal their scheme and artificially inflate the mortgage company's financial status. The defendants then placed the non-conforming loans into the Government National Mortgage Association pools and fraudulently certified they met all of the requirements. Total losses exceed $78 million.

- A civil settlement agreement was reached regarding a *qui tam* lawsuit that was filed against a law firm under the False Claims Act. The lawsuit alleged that the law firm made numerous false claims involving mortgage loan guarantees granted by VA and HUD by falsely claiming reimbursement for fees they did not incur during VA and FHA foreclosure sales. The allegations were substantiated and the firm agreed to pay $676,852 to settle the case. Single damages, which are half of the total amount of the settlement or $338,426, will go to VA and HUD to cover losses. One quarter of the settlement or $169,213 will go to the realtor, and the remaining $169,213 will go to the Department of Justice.

Procurement Fraud

- A former VBA loan program specialist and a Government contractor were charged with conspiracy to defraud, accepting bribes, and making false statements after a VA OIG investigation revealed the employee directed Government contracts to work on VA properties acquired through the loan guaranty program to the contractor and four others, who have yet to be indicted. The indictments further allege these contractors purchased products for the employee's personal use and maintained and made improvements to the employee's residence and to a home belonging to one of the employee's relatives. The indictment also alleges the employee fraudulently used his authority to ensure Government contracts were awarded to these contractors and that fraudulent invoices were paid. Civil action was also filed in this case on behalf of the VA seeking monetary recoveries under the False Claims Act from the contractor and his sister, the owner of a cleaning company. The action was taken based on false and misleading claims they made for payment of invoices they submitted to the VA. The False Claims Act allows the Government to collect up to three times the amount of the fraud and up to $11,000 per false claim. Collectively, the contractor and his sister face over $2.1 million

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Case claims millions in fraud, bribes

Reaction: Derry man will mount vigorous defense; Salem man faces resignation call.

By PAT HAMMOND
Sunday News Staff

In a criminal case characterized by an official in the Veterans Administration's Northeast Regional office as "highly significant," the United States District Court, District of New Hampshire, is charging a New Hampshire VA worker with bribery and conspiracy to defraud the U.S. government of more than $4 million.

Robert Mayer of Salem, a former Loan Program specialist in the VA's Regional Loan Center in Manchester, will be arraigned tomorrow in the U.S. District Court in Concord. He will be charged with one count of conspiracy to defraud the U.S. and two counts of being a public official accepting bribes, all allegedly taking place between January 1996 and February 2002.

"It is a highly significant case not only for the dollar amount but for concerns about the integrity of the program," Bruce Sackman, special agent in charge, VA Office of the Inspector General for the Northeast Region, said on Friday.

"This is definitely at the top — if not, then near the top — in dollar amounts that I have seen, and I have been with the VA since 1980," Sackman said in an interview while on the Long Island (N.Y.) Ferry.

"I guarantee you Mayer will never work for the VA again, even if he is acquitted," Sackman said. "That's a lot of damage to the VA and to the integrity of the program."

The indictment against Mayer and, in a companion filing, against John Burke of Derry, was filed by the U.S. District Court, District of New Hampshire on behalf of the U.S. Government. They were signed by New Hampshire's U.S. Attorney Thomas Colantuono and Robert M. Kinsella, Assistant United States Attorney, District of New Hampshire.

Colantuono said yesterday that the $4 million figure represents the value of the contracts in question.

In the companion filing, Burke of Derry, owner of Burke

► See Fraud, Page B6

JANINE GILBERTSON

This is the Salem home of Robert Mayer, a former Loan Program specialist in the VA's Regional Loan Center in Manchester. Mayer will be arraigned tomorrow in the U.S. District Court in Concord. He will be charged with one count of conspiracy to defraud the U.S. and two counts of being a public official accepting bribes.

dollars in damages, restitution, and penalties, and may have to forfeit any assets, such as their home, to the United States Government.

Fugitive Felon Program

The Office of Investigations Fugitive Felon Program identifies 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 matches between fugitive felon files of law enforcement organizations and more than 11 million records contained in 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. Information is then provided to the Department so that benefits may be suspended and to initiate recovery action for overpayments.

To date, Memoranda of Understanding/ Agreements have been completed with the U.S. Marshals Service and the National Crime Information Center, as well as with the States of California, New York, Tennessee, Washington, Pennsylvania, Ohio, and Massachusetts. Additional agreements are in the process of being negotiated with other states.

The program has led to additional cooperative efforts between the VA OIG, VBA, and VHA in an attempt to implement this new initiative. Investigative leads provided to law enforcement agencies since the inception of the program have led to the arrest of fugitives wanted for murder, manslaughter, sexual assault, robbery, drug offenses, and other

serious felonies. The apprehension of these subjects has made VA facilities safer for our veterans, employees, and the general public.

The table below identifies the statistics relating to the Fugitive Felon Program during this reporting period, as well as from the inception of the program.

The following are examples of fugitive felon apprehension cases:

- The VA OIG, working with a U.S. Marshals Service Fugitive Apprehension Strike Team, arrested a fugitive veteran who was wanted for the attempted capital murder of a police officer.

- A veteran was arrested on six outstanding state warrants for sexually related crimes. A VA OIG agent, VA police, and U.S. deputy marshals made the arrest at a VAMC. The fugitive was taken into custody without incident and is pending extradition.

- A fugitive felon was apprehended based on information provided by the VA OIG Fugitive Felon Program to a local law enforcement agency. The fugitive had been wanted on a robbery charge since 1976.

- As a result of information provided by the VA Fugitive Felon Program, a veteran was apprehended in another country. The veteran was wanted on a probation violation after being convicted of aggravated sexual battery upon a child. The subject was returned to the United States after his arrest and was sentenced to an additional extensive period of incarceration.

- With the assistance of VA OIG agents, a fugitive veteran was taken into custody and was transported by local authorities to await extradition. The veteran had previously been charged with aggravated assault with a deadly weapon.

Fugitive Felon Program	This Reporting Period	Total
Felony Warrants Received from Participating Agencies	1.7M	3.5M
Matched Records	11,025	38,686
Referred to Law Enforcement Agency Which Holds the Warrant	1,947	12,301
Arrests Made by Law Enforcement Agency Which Holds the Warrant	82	211
Arrests Made by OIG	99	294
Referrals to VA for Benefits Suspension	2,671	9,201
Estimated Identified Overpayments	$10.3M	$57.1M
Estimated Cost Avoidance	$19M	$119M

M=Million

OIG Questioned Document Forensic Laboratory

The Office of Investigations operates a questioned document forensic laboratory 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 35 completed laboratory cases during this semiannual period.

Laboratory Cases for the Period	
Requester	Cases Completed
OIG Office of Investigations	15
VA Top Management	4
VA Regional Offices	16
TOTAL	**35**

The following are examples of completed laboratory reports:

- A veteran appealed an adverse Board of Veterans' Appeals decision to the U.S. Court of Appeals for Veterans Claims. He provided his attorney with a medical record which contained information that was justification for VA benefits. The Appellate Attorney with the General Counsel requested laboratory examinations to determine authenticity of the medical record. Laboratory examinations determined the medical record provided by the veteran was not authentic, but was an altered copy of a medical record contained in his claims folder.

- In preparation for a San Juan, Puerto Rico, proactive investigation, claims folders and copies of U.S. Treasury checks were submitted to the laboratory. The purpose of the laboratory examinations was to determine the authenticity of the signatures on the checks. The laboratory determined the signatures on the checks were not genuine. One case revealed the true veteran had died and his signature on the VA checks had been forged which cost the Government over $100,000. The forger then used the true veteran's DD Form 214 to create an identity of another individual that did not exist, in order to draw additional VA benefits.

OIG Computer Crimes Forensic Laboratory

The Office of Investigations operates a computer crimes forensic laboratory in Washington, DC. The laboratory offers forensic support in the examination of computers, removable storage media, personal digital assistants, and other digital storage devices. The laboratory provides support to VA OIG special agents nationwide in the investigations of fraud, misuse of Government equipment, identity theft, and child pornography.

The capability of the VA OIG Computer Crimes and Forensics laboratory has expanded to conduct data collection from most forms of electronic storage devices, to include new hard drive technology and personal digital assistants. The Computer Crimes and Forensics lab has also developed and established contacts and working

relationships with Government agencies domestically and internationally, and is actively involved in multi-agency criminal investigations involving electronic data.

Additionally, in step with the new investigative equipment acquisitions for the field, the Computer Crimes and Forensics lab is actively working in providing technical assistance and backup support with several components of investigative equipment, to include global positioning systems, theft detection, marking and tagging agents, and electronic surveillance.

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

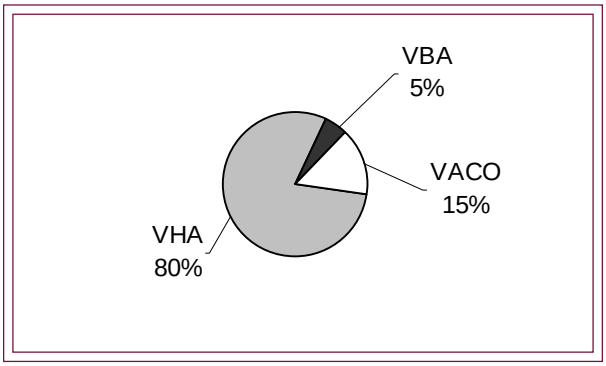
Laboratory Cases for the Period	
Child/Adult Pornography	4
Fraud	3
Misuse of Government Systems	1
Total	8

II. ADMINISTRATIVE INVESTIGATIONS DIVISION

This Division is generally responsible for investigating allegations against senior VA officials and other high profile matters of interest to the Congress and the Department.

Resources

The Administrative Investigations Division has seven FTE allocated. The following chart shows the percentage of resources used in reviewing allegations by program area.



Overall Performance

Output

- The Division closed 12 cases and issued 4 reports and 4 advisory memoranda, and participated in a joint Hotline with the OIG Offices of Audit and Healthcare Inspections.

Outcomes

- VA managers agreed to take 14 administrative sanctions, including personnel actions against 10 officials, and corrective actions in 4 instances to improve operations and activities. The corrective actions included charging a full-time physician annual leave for unauthorized absences, improving the monitoring of part-time physicians' time and attendance, correcting the improper transfer and expenditure

of funds, and billing a former employee for funds he improperly spent.

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

Preferential Treatment

- An administrative investigation substantiated that a VA medical center associate director violated ethical conduct standards and Federal acquisition regulations by giving preferential treatment to a company while that company had, and was seeking, official business with VA. Among other actions, the associate director indicated he was considering future employment with the company while involved in an official VA capacity in decisions affecting it, provided non-public information to the company, initiated plans for a business arrangement that could have financially benefited it, and socialized with company officials. The investigation also substantiated that another medical center employee violated these regulations by creating the appearance that she gave the company preferential treatment. VHA officials agreed to take appropriate administrative action against the two employees.

Misuse of Time by Physicians

- Two administrative investigations substantiated misuse of official VA time by a physician. In one case, a part-time physician routinely did not work her regular tour of duty, working instead for other employers, and did not request or receive supervisory approval to adjust her schedule. The physician also submitted subsidiary time and attendance reports that did not accurately reflect the hours she actually worked at VA. In the second case, a full-time physician routinely misused his official VA time by arriving for duty 30 to 90 minutes later than his scheduled tour of duty several times a week. VHA officials agreed to take appropriate administrative action against both physicians and their supervisors, charge the full-time physician a full day of annual leave for each day of unauthorized absence, and take corrective actions to ensure such violations are not repeated.

III. ANALYSIS AND OVERSIGHT DIVISION

This Division has oversight responsibilities for all operations conducted by the Office of Investigations through a detailed inspection program to ensure the agency is in full compliance with the quality standards for investigations published by the PCIE. The Division is also responsible for scheduling and facilitating operational and management training for all employees within the Office of Investigations. Additionally, the Division is the primary point of contact for law enforcement communications through the National Crime Information Center (NCIC), the National Law Enforcement Telecommunications System (NLETS), the Financial Crimes Criminal Enforcement Network, and other law enforcement professional organizations.

Resources

The Analysis and Oversight Division has six FTE allocated.

Overall Performance

Output and Outcomes

During the reporting period, the Division accomplished the following:

- Completed a PCIE qualitative assessment review of the investigative operations of another OIG pursuant to the IG Act and Attorney General guidelines.

- Conducted five regional training seminars for agents that included firearms qualification and simmunitions scenario-based exercises, use of force policy discussion and report writing, defensive tactics and related practical drills, legal update, and physical conditioning assessment.

- Planned, coordinated, and managed a training conference for all personnel assigned to the Office of Investigations that included discussions on such topics as agency policy directives, legal authority, personnel practices, the PCIE peer review process, VA OIG's computer crime investigative program and proper evidence gathering techniques, investigative tools offered by the private sector, and retirement planning.

- Scheduled and/or facilitated 85 instances of training involving 59 employees for such courses as Criminal Investigator Training Program, IG Transitional Training Program, Continuing Legal Education, Interviewing Techniques, Firearms Instructor Program, Defensive Tactics Training Program, and Office of Personnel Management (OPM) Management Training.

- Conducted 251 NCIC and the NLETS checks in support of criminal investigations.

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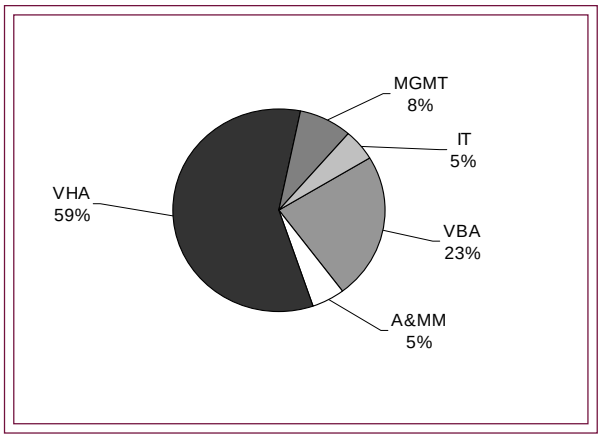
OFFICE OF AUDIT

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 17 FTE allocated for its headquarters and 160 FTE in 11 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 41 audits, evaluations, and reviews for an output efficiency of 1 report per 3.8 FTE during this 6-month period. We also issued an additional 49 contract reviews, for an efficiency of 2.0 reports per FTE for the 6-month period. In addition, staff assisted in a joint Hotline with OIG Offices of Healthcare Inspections and Investigations.

Outcome

- Recommendations to enhance operations and correct operating deficiencies have associated monetary benefits totaling approximately $704.4 million. In addition, contract reviews identified monetary benefits of $122.6 million associated with the results of preaward and postaward contract reviews.

Customer Satisfaction

- Customer satisfaction with performance and financial audits and evaluations during this reporting period was 4.7 on a scale of 5.0. The average customer satisfaction rating achieved for contract reviews was 4.5 out of a possible 5.0.

Veterans Health Administration

Resource Utilization

Issue: VHA's Transitional Pharmacy Benefit Program.
Conclusion: Implementation efforts hindered by incomplete information and different view of policy guidelines.
Impact: Improved access to VA supplied prescription drugs.

The evaluation was initiated at the request of the Secretary to determine why program costs ran far below original estimates. We concluded the program achieved its primary goal of improving access to VA supplied prescription drugs for many veterans who were on lengthy waiting lists for their first primary care appointment. However, the number of veterans eligible for participation and associated costs were significantly less than projected, due to changing policies, advanced appointment dates, and stricter eligibility rules.

We found that implementation of the program, or a future similar initiative, could be improved. VHA program officials need to retrospectively review the planning phase of this program because implementation efforts were hindered by incomplete or inconsistent information and differing views on interpreting policy guidelines and goals. VHA officials also needed to better oversee the implementation of the program to ensure consistency at the VISN and facility levels. In addition, VHA officials needed to develop and implement a comprehensive management reporting system tailored specifically for such a program to enable them to accurately review and analyze the success of the initiative.

We recommend that the Acting Under Secretary for Health take actions to ensure that all participating VISNs and facilities workloads and costs associated with the program are accurately reported. This effort will enable VHA to better evaluate the success of the program and to determine whether any additional follow-up actions need to be taken. The Acting Under Secretary for Health agreed with the report and provided an acceptable plan to address the program reporting issues identified. We will continue to follow up on planned actions until they are completed. *(Evaluation of VHA's Transitional Pharmacy Benefit, 04-00310-212, 9/27/04)*

Quality of Care

Issue: A full-time physician's time and attendance at VAMC Salem, VA.
Conclusion: Physician did not meet her responsibilities.
Impact: Strengthened controls over time and attendance.

A complainant alleged that a full-time physician worked only 20 to 25 hours of her 40-hour workweek, generally arriving at the VAMC between 9 and 10 a.m. and departing at 3 p.m. The allegation was substantiated. The physician had not been working her 40-hour workweek. Her supervisor was aware of the situation, but failed to formally address the problem. We recommended that appropriate administrative action be taken against the physician and hersupervisor. In addition, we learned that

service-level policy memorandum had been issued that conflicted with VA duty and leave policy.

We recommended that this memorandum be rescinded. The VISN and VAMC Directors agreed and provided acceptable implementation plans. *(Evaluation of Allegation of Physician Time and Attendance Abuse at the Salem VA Medical Center, Salem, VA ,04-01757-205, 9/10/04)*

Office of Management

VA's Consolidated Financial Statements (CFS)

Issue: Financial management and information technology security.
Conclusion: Eight management letters issued to improve controls.
Impact: Improved controls over access to financial systems.

The independent public accounting firm, Deloitte & Touche LLP, performed the audit of VA's CFS under contract to the OIG. As part of the audit, we issued three management letters addressing general controls over access to the data centers which run financial systems and five management letters addressing application controls over access to specific financial systems. The management letters for the general controls provided the status of prior year findings and recommendations and provided additional findings in the areas of information systems operations, information security, database implementation and support, network support, and systems software support. The management letters for the applications controls provided the status of prior year findings and recommendations in the areas of security administration, application systems security, application systems implementation and maintenance, and segregation of duties.

The eight management letters related to management of three VA data centers and five application systems:

(i) Management Letter, Audit of VA's FYs 2003 and 2002 CFS General Computer Controls Review at the Austin Automation Center, *03-01237-132, 4/19/04*;
(ii) Management Letter, Audit of VA's FYs 2003 and 2002 CFS General Computer Controls Review at the Philadelphia Information Technology Center and Insurance Center, *03-01237-133, 4/19/04*;
(iii) Management Letter, Audit of VA's FYs 2003 and 2002 CFS General Computer Controls Review at the Hines Information Technology Center, *03-01237-134, 4/19/04*;
(iv) Management Letter, Audit of VA's FYs 2003 and 2002 CFS Compensation and Pension Application Follow-up Review *03- 01237-192 8/26/04*;
(v) Management Letter, Audit of VA's FYs 2003 and 2002 CFS Financial Management System Application Follow-up Review, *03-01237-193, 8/26/04*;
(vi) Management Letter, Audit of VA's FYs 2003 and 2002 CFS Personnel and Accounting Integrated Data Application Follow-up Review, *03-01237-194, 8/26/04*;
(vii) Management Letter, Audit of VA's FYs 2003 and 2002 CFS Loan Guaranty System Application Follow-up Review, *03-01237-195, 8/26/04*; and
(viii) Management Letter, Audit of VA's FYs 2003 and 2002 CFS Integrated Funds Distribution, Control Point Activity, Accounting and Procurement Application Review, *03-01237-198, 8/30/04*.

Preaward Contract Reviews

Issue: Federal Supply Schedule (FSS) vendors' best prices.
Conclusion: Vendors can offer better prices to VA.
Impact: Potential better use of $120.7 million.

Preaward reviews of 32 FSS and cost-per-test offers made recommendations for potential better use of $120.7 million. Recommendations to negotiate lower contract prices were made because the vendors 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 $777,400.

We completed reviews of seven proposals from VA affiliated medical schools involving the acquisition of scarce medical specialists' services. We concluded the contracting officers should negotiate reductions of $777,400 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 identified.
Impact: Recovery of $1.1 million.

We completed five reviews of vendors' contractual compliance with the specific pricing provisions of their FSS contracts. The reviews resulted in recoveries of $871,000. We also completed five drug pricing Public Law 102-585 compliance reviews at pharmaceutical vendors. The reviews resulted in recoveries of $229,000.

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 VA's contracts are fairly priced.

Multiple Office Action

Issue: VA Workers' Compensation Program (WCP).
Conclusion: VA continues to be at risk for WCP abuse, fraud, and unnecessary costs.
Impact: Reduction in program costs by $696.2 million.

The audit found that VA continues to be at risk for significant WCP abuse, fraud, and unnecessary costs because of inadequate case management and fraud detection. Previous OIG audit recommendations to enhance the Department's case management and fraud detection efforts, and avoid inappropriate dual benefit payments were not fully implemented. Additionally, we found that VA's WCP costs are being impacted because of employee injuries associated with violent patient incidents. The Department is also at risk for

unnecessary WCP costs due to lack of action/ responses on case inquiries to the Department of Labor, which administers the Federal Employees' Compensation Act.

Ineffective WCP case management and program fraud results in potential unnecessary and/or inappropriate costs to the Department totaling $42.7 million annually. These costs represent significant potential lifetime compensation payments to claimants totaling $696.2 million. Additionally, an estimated $112.6 million in avoidable past compensation payments were made that are not recoverable, because VA missed opportunities to return employees back to work.

The Assistant Secretary for Management agreed with the report and will continue to designate the WCP as an internal high priority area with increased program monitoring and oversight. The Acting Assistant Secretary for Human Resources and Administration agreed to strengthen VA's WCP and reduce unnecessary program costs. The Acting Assistant Secretary also agreed with the estimated monetary benefits and indicated that it was a conservative estimate. While the Acting Assistant Secretary's comments do not include detailed implementation plans with milestone completion dates, responsible program officials advised that work on these plans is in process and will be provided for OIG review. (*Follow-up Audit of Department of Veterans Affairs Workers' Compensation Program Cost, 02-03056-182, 8/13/04*)

Issue: VA Government purchase card program.

Conclusion: Improved controls needed to detect fraud and improper uses of purchase cards.

Impact: Strengthened controls over purchase cards.

The OIG evaluated the VA Government purchase card program to determine the effectiveness of internal controls to prevent and detect fraudulent, improper, or questionable purchases. The evaluation was conducted utilizing the results of investigations, hotlines, and CAP reviews performed at VAMCs and VAROs. The evaluation also included separate data mining analyses of purchase card transactions at five VA facilities.

The OIG issued an earlier audit report on VA's Government purchase card program on February 12, 1999 (*Report Number 9R3-E99-037*). The audit showed that management controls were not effectively implemented to ensure the integrity of the Government purchase card program and maximum benefits were not being realized. Since this audit, the OIG issued 83 reports during the period April 1999 through September 2003, which have continued to identify internal control weaknesses in the Government purchase card program. Over the years, the OIG reported numerous instances of improper and questionable uses of purchase cards, including some instances of fraudulent activity.

We identified internal controls that need to be fully implemented to provide management greater assurance that purchase cards are used properly. Areas needing improvement included: (i) closer supervision and better training of cardholders and approving officials, (ii) timely reconciliation of purchase card transactions by cardholders, (iii) timely and thorough certifications of transactions by approving officials to ensure competitive prices are obtained and preferred purchasing sources are used, (iv) prevention of improper purchases, and (v) avoidance of split purchases. In addition, facility managers needed

to conduct effective focused audits to provide greater assurance that: (i) duties are appropriately segregated, (ii) cardholders and approving officials are properly trained, (iii) the span of control for approving officials is appropriate, and (iv) questionable transactions are identified and validated. The Under Secretary for Health, the Under Secretary for Benefits, and the Assistant Secretary for Management agreed and provided acceptable improvement plans. (*Evaluation of the VA Government Purchase Card Program, 02-01481-135, 4/26/04*)

Joint Review

Issue: Patient care and administrative issues at VAMC Bay Pines, and deployment of the Core Financial and Logistics System (CoreFLS).
Conclusion: Mismanagement and substandard medical care results in VA reevaluating its multi-millioned dollar CoreFLS.
Impact: Better use of funds.

The OIG conducted an evaluation of selected patient care and administrative issues at the Bay Pines VA Medical Center (BPVAMC), Bay Pines, FL. The evaluation also included reviews of VA Central Office contract procedures and the deployment of the CoreFLS. We confirmed reports of substandard patient care and services at the BPVAMC and found that many of the conditions existed prior to the deployment of CoreFLS. We concluded that the contracting and monitoring of the CoreFLS project was not adequate and the deployment of CoreFLS encountered multiple problems. Even though VA had obligated $249 million of the $472 million budgeted for CoreFLS, it had not been successfully deployed at a VAMC. Inadequate BPVAMC management resulted in dysfunctional clinical and administrative operations. We also found that medical care in selected clinical services was not adequate. VA's management of the CoreFLS project did not protect the interest of the Government. BPVAMC was not adequately prepared for CoreFLS deployment. CoreFLS security weaknesses placed programs and data at risk. Senior leadership did not respond adequately to supply, processing, and distribution warnings and did not ensure adequate preparation for CoreFLS testing.

We made a number of recommendations to improve clinical and administrative controls and take certain actions at the BPVAMC. Senior VA management concurred with the recommendations and provided acceptable implementation plans. *(Issue at VA Medical Center Bay Pines, Florida, and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS), 04-01371-177, dated 8/11/04)*

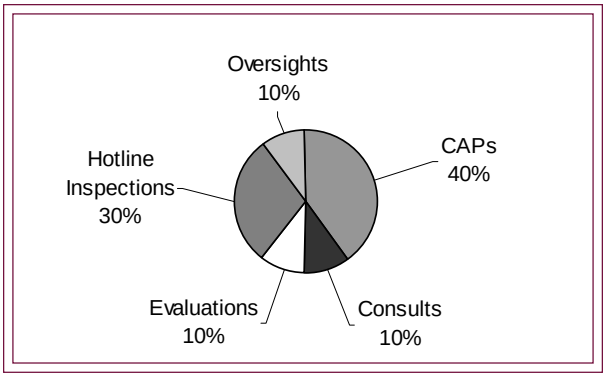
OFFICE OF HEALTHCARE INSPECTIONS

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 48 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 cases.



Overall Performance

Output

- Participated in 22 CAP reviews to evaluate health care issues and made 81 recommendations and 23 suggestions that will improve operations, activities, and the care and services provided to patients.

- Completed three summary evaluations and one national inspection and made 28 recommendations to improve patient care and efficiencies in the community residential care program; improve patient and employee safety in the management of violent patients; enhance the quality management program; and assist with nurse staffing decisions and improve nurse job satisfaction, recruitment, and retention.

- Completed nine Hotline cases, which consisted of reviews of 32 issues and one joint Hotline with OIG Offices of Audit and Investigations, which consisted of 22 health care related issues. Administratively closed three of the cases and issued reports on the remaining seven cases. Made 40 recommendations that will improve the health care and services provided to patients.

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

- Oversaw the work of VHA's Office of the Medical Inspector on five projects.

- Completed six technical reviews on recommended legislation, new and revised policies, new program initiatives, and external draft reports.

- Reviewed the responses to 131 Hotline cases consisting of 170 issues that were referred to VHA managers for review.

Outcomes

- Overall, OHI made or monitored the implementation of 149 recommendations and 23 suggestions to improve the quality of care and

services provided to patients and their families. VHA managers agreed with all of our recommendations and provided acceptable implementation plans. VHA implementation actions will improve clinical care delivery, management efficiency, patient safety, and will hold employees accountable for their actions. In addition, a national inspection on nursing resources identified areas where $42.4 million in costs could be better used.

Veterans Health Administration

National Inspection

Issue: Management of nursing resources.
Conclusion: VHA had not mandated the use of national standardized nurse staffing methodology as recommended by the OIG in 1989.
Impact: Improved nurse job satisfaction, patient care, and reduced costs by $42.4 million.

Our review focused primarily on FY 2002 activities. We found facility managers could have managed their resources better to provide patient care if VHA developed and implemented safe patient care. These practices could have been avoided had VHA developed and implemented procedures to ensure: (i) efficient management of nurse staffing resources through the use of consistent staffing methodologies, standards, and data systems; (ii) monitoring of the potential impact of nurse staffing issues on patient care; (iii) effective use of recruitment and retention strategies; and (iv) appropriate management response to issues that influence registered nurse job satisfaction.

Despite frequently voiced concerns about staffing shortages, the ten sites visited generally met patient care demands. We made recommendations to improve the management of nursing resources, promote high quality patient care, facilitate nursing recruitment and retention efforts, and enhance nurses' job satisfaction. We also identified areas where costs totaling $42.4 million could be reduced or funds better used. The Acting Under Secretary for Health concurred with the findings and recommendations, including the estimate for monetary benefits, and provided responsive implementation plans. *(Healthcare Inspection, Evaluation of Nurse Staffing in VHA Facilities, 03-00079-183, 8/13/04)*

Summary Evaluations

Issue: VHA's management of violent patients.
Conclusion: VHA needed to improve procedures and incident reporting.
Impact: Improved patient and employee safety.

The purpose of the review was to conduct an evaluation of VHA processes to manage violent patient behaviors. The evaluation was conducted to determine the effectiveness of VHA's program to identify violent patients, and to minimize the risk to employees, patients, and others visiting VA facilities from threatening and violent patient behaviors.

To improve the management of violent patients, VHA needed to: (i) establish interdisciplinary response teams in each facility that are specifically trained in violence management; (ii) develop a consistent method of identifying and reporting violent incidents, ensure complete information is available to employees who are responsible for analyzing and trending these data, and recommending corrective strategies; (iii) establish

interdisciplinary committees to review and track violent incidents for the purpose of developing violence management and prevention strategies; and (iv) implement guidelines for the appropriate use of automated warning flags and ensure they are applied consistently throughout the system, and all employees have access to computer systems that will flag patients' records when there are histories of violence. The former Under Secretary of Health concurred and provided acceptable improvement plans. *(Healthcare Inspection, Healthcare Program Evaluation VHA's Management of Violent Patients, 02-01747-139, 5/3/04)*

Issue: VHA community residential care program.
Conclusion: Compliance with policies, inspections, and patient assessments needed improvement.
Impact: Improved monitoring practices and controls.

The purpose of this review was to evaluate whether VA medical facilities inspect their community residential care homes; veterans are appropriately assessed, placed, and followed; caregivers are qualified to meet veterans' needs; and incompetent veterans' care is coordinated with VBA.

We recommended the Acting Under Secretary for Health ensure: (i) program officials review existing policies governing the program and ensure all aspects of the guidelines are current; (ii) inspections occur as mandated, and VAMC program employees understand the requirements for interdisciplinary patient assessments, communication with caregivers, and post-placement follow-up visits; (iii) VAMC program employees are re-educated about the standard requiring annual caregiver training, and establish a method for monitoring whether VA employees own or operate VA approved homes; and (iv) new guidelines are issued requiring caregiver background clearances and statements of agreement whenever patients are referred to assisted living facilities not approved by VA. The Acting Under Secretary for Health agreed and provided acceptable improvement plans. *(Healthcare Inspection, VHA's Community Residential Care Program, 03-00391-138, 5/3/04)*

Issue: Quality management programs.
Conclusion: VHA needs a stronger system for corrective action implementation and evaluation.
Impact: Improved quality of care and patient safety.

The purposes of this review were to determine whether: (1) VHA facilities had comprehensive, effective programs designed to monitor patient care activities and coordinate improvement efforts; and (2) VHA facility senior managers actively supported quality management efforts and appropriately responded to results.

All of the facilities reviewed during 2003 had established comprehensive programs and performed ongoing reviews and analyses of mandatory areas. We noted improvements in several areas compared with our 2002 review. However, facility senior managers need to strengthen programs through increased attention to the disclosure of adverse events, the utilization management program, the patient complaints program, and medical record documentation reviews. Senior managers need to strengthen designated employees' data analysis skills, benchmarking, and corrective action identification, implementation, and evaluation across all monitors.

Because of continued weaknesses in data management, particularly the implementation and evaluation of corrective actions, facility senior managers need to clearly state their expectations to all managers, program coordinators, and committee chairpersons, who are responsible for quality management monitors, that corrective actions must be evaluated until resolution is achieved. To provide reasonable assurance that its facilities are thoroughly addressing quality of care and patient safety issues, VHA needs a stronger system for corrective action implementation and evaluation. The Acting Under Secretary for Health concurred and provided responsive implementation plans. *(Healthcare Inspection, Evaluation of Quality Management in VHA Facilities, Fiscal Year 2003, 03-00312-169, 7/14/04)*

Healthcare Inspections

Issue: Suspicious death.
Conclusion: Nursing staff did not ensure patient's safety or provide acceptable standards of care.
Impact: Incident appeared to be isolated.

We initiated an inspection in response to allegations that a patient's death was caused by nursing home staff leaving the patient unattended for several hours on the patio without medications or water. We also reviewed allegations that VAMC staff failed to follow policy, attempted to cover up the facts, and was insensitive when informing the next-of-kin of the patient's death. We substantiated the allegation that nursing staff did not ensure the patient's safety or provide care which met acceptable standards or as prescribed in the patient's care plan on the day of his death. The patient was considered a high safety risk and his care plan required nursing staff to check on him every 2 hours. We confirmed nursing staff had no contact with the patient for over 5 hours, even though he was 92 years old with a history of seizures and falls.

We did not substantiate the allegation that VAMC managers attempted to cover up the incident, but noted inconsistencies in documentation and interview statements that may have reflected employees' efforts to minimize their own accountability. We could not substantiate the allegation that the patient's death was reported insensitively or that the patient died under suspicious circumstances. The autopsy report stated the patient died of natural causes and our medical review did not identify any significant lapses in his medical care.

Washington VA Medical Center
Washington, DC

However, we did find employees did not comply with local code blue policy regarding cardiopulmonary resuscitation procedures or documentation. We also found some nursing staff did not comply with bar code medication administration procedures when they recorded medication administration long after medications were actually administered. We made six recommendations. The VISN and VAMC Directors concurred with the recommendations and provided responsive implementation plans. *(Healthcare Inspection, Quality of Care Issues, Washington, DC VAMC, 03-02110-150, 5/20/04)*

Issue: Allegations regarding patient care and environmental issues.
Conclusion: Did not substantiate the allegations.
Impact: Safe and clean environment.

We received allegations regarding patient care and environmental issues on the Spinal Cord Injury unit at the VAMC San Juan. We did not substantiate the allegations. Overall, we found facility managers and clinicians were responsive to the complainant's concerns about medical record documentation. Facility clinicians reviewed and amended the subject patient's medical records where appropriate.

We found the unit to be clean and well maintained. Fire safety and emergency evacuation procedures were in place, and employees routinely participated in practice drills. Managers ensured that unit personnel received safe patient handling and vertical evacuation training. Managers enhanced existing pest control measures by installing an air curtain at the patio door. Although we found two instances when nurse staffing did not meet the facility's own standards, four additional nursing personnel have since been hired to fill specific shifts, thus reducing the likelihood of insufficient staffing on evening, night, and weekend shifts. The unit meets VHA's staffing requirements. Because facility managers were making appropriate efforts to address the identified deficiencies, we did not make any recommendations. *(Healthcare Inspection, Inspection of Patient Care and Environmental Issues on the Spinal Cord Injury Unit, VAMC San Juan, PR, 04-00037-151, 5/28/04)*

Issue: Alleged lack of physician responsiveness.
Conclusion: Patient received appropriate therapeutic interventions; however, nurses did not timely communicate the patient's statement that he was dying to the physician.
Impact: Improved communication between clinicians.

We reviewed the case of an alleged lack of physician responsiveness to an inpatient's requests to see a physician and an alleged lack of timely medical evaluation and intervention when the patient was in a state of distress.

We found communication broke down in that the patient's requests to see a physician were not communicated to the appropriate physician in a timely manner. However, the patient had been assessed by the nursing staff, who evaluated the patient and concluded he was stable. Later, when the patient's condition took a turn for the worse, he was immediately evaluated by the appropriate physicians.

In this review we also identified several problems with medical record documentation, which most probably did not contain clinical significance. In

VA Medical Center
Bay Pines, FL

addition, we identified areas for possible further clinical review and improvement and issues surrounding a post-mortem request for an autopsy. The VISN Director concurred and provided responsive implementation plans. *(Healthcare Inspection, Review of Quality of Care and Communication Issues, VAMC Bay Pines, FL, 04-01371-153, 6/4/2004)*

Issue: Allegation about abuse of power and increased mortality and morbidity rates.
Conclusion: Did not substantiate allegation; however, resident supervision documentation needed improvement.
Impact: Improved medical record documentation.

We conducted an inspection in response to a complainant's allegations about abuse of power and increased morbidity and mortality rates. We did not substantiate the allegations that medical center managers abused their power, or that morbidity and mortality rates increased due to residents performing operative procedures. However, we did find that attending surgeons did not always co-sign residents' pre-operative and operative notes. Furthermore, documentation did not always reflect personal involvement of the attending surgeons or documentation of resident supervision appropriate for major changes in patients' conditions. We made one recommendation for improvement. The VISN and Medical Center Directors concurred with the recommendation and provided responsive implementation plans. *(Healthcare Inspection, Allegations of Abuse of Power and Increased Morbidity and Mortality Department of Surgery, VAMC Memphis, TN, 04-00275-175, 8/6/04)*

VA Medical Center
Memphis, TN

Issue: Patient safety and transportation services deficiencies.
Conclusion: Lack of record keeping made it difficult to determine vendors' performance acceptability.
Impact: Improved vendor compliance with contract requirements.

VA Medical Center
Augusta, GA

We conducted an inspection in response to allegations that patient transport services endangered the lives of veterans and the contracted vendor was awarded the contract so consistently that other vendors chose not to bid. We substantiated some of the patient's allegations regarding her experiences with the transport services. Certain provisions within the contract were unenforceable and medical center staff did

not monitor the contract requirements to ensure the vendor met safety and maintenance standards. Additionally, medical center staff did not verify invoices before payment for services. Overall, the lack of formal recordkeeping made it difficult to determine whether the vendor's performance was acceptable. We made several recommendations to improve operations. The VISN and VAMC Directors concurred and provided responsive implementation plans. (*Healthcare Inspection, Patient Travel and Contract Transportation Deficiencies, VAMC Augusta, GA, 04-00225-184, 8/13/04)*

San Diego Healthcare System
San Diego, CA

Issue: Narcotics diversion.
Conclusion: Numerous irregular practices related to controlled substances.
Impact: Improved controls.

OHI collaborated with OIG investigators in a criminal drug diversion investigation that exposed serious problems in controlled substances management at the medical center. Numerous irregular practices related to controlled substances use over a period of at least 1 year failed to raise suspicions with the charge nurse or supervisor. During a 6-month period, one nurse committed 92 infractions involving nine different narcotic pain medications in more than 400 doses. The medical center policy required that nursing supervisors perform and document random checks of entries on the controlled substances control sheets for clarity and completeness and compare them with patients' medication administration histories. We found no evidence that these checks were performed. The policy required a nurse from the out-going and oncoming shifts count controlled substances together; the nurse frequently counted alone. The policy defined the process for witnessing and countersigning the wasting of a partial or whole controlled substance dose. The nurse did not follow the defined process. The policy required the charge nurse determine the amount of controlled substances needed and place an order. The nurse ordered controlled substances even though she was never designated as the charge nurse.

We also found the nurse frequently gave controlled substances to patients assigned to other nurses when they were on break, even though some of these nurses specifically instructed the nurse not to. It was apparent that many observations made by the other night shift nurses over a period of several months were not brought to the attention of anyone in a position of authority. As a result, suspicious practices were allowed to continue. We made three recommendations to improve controls. The VISN and Medical Center Directors concurred and provided responsive implementation plans. *(Healthcare Inspection, Controlled Substances Management Issues, VA San Diego Healthcare System, San Diego, CA, 01-00637-203, 9/9/2004)*

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OFFICE OF MANAGEMENT & ADMINISTRATION

Mission Statement

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

The Office of Management and Administration is responsible for a wide range of administrative and operational support functions. The Office includes five divisions.

I. Hotline – 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 Investigations, Audit, and Healthcare Inspections, or to impartial VA components for review.

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

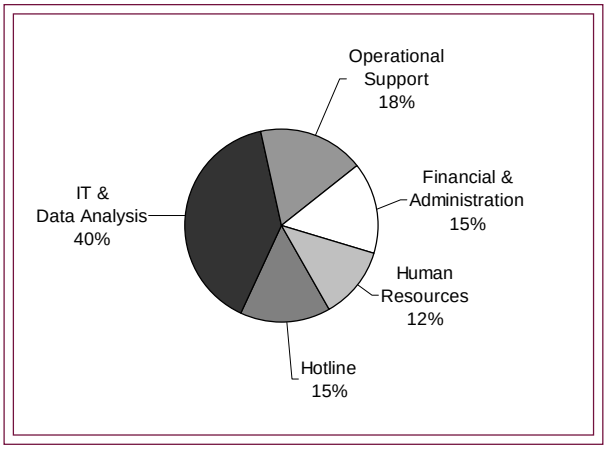
III. Information Technology (IT) and Data Analysis – Manages nationwide IT support, systems development and integration; represents the OIG on numerous intra- and inter-agency IT organizations; and does strategic IT planning for all OIG requirements. The Division maintains the Master Case Index (MCI) 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.

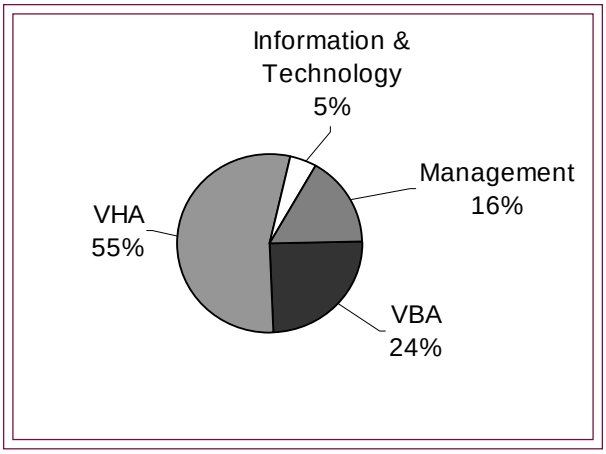
IV. Financial and Administrative Support – Responsible for OIG financial operations, including budget formulation and execution, and all other OIG administrative support services.

V. Human Resources Management – 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 59 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. Government Accountability 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 10,529 contacts. This resulted in opening 671 cases. The OIG reviewed 164 (24 percent) of these and referred the remaining 507 cases to VA program offices for review.

Output

- During the reporting period, Hotline staff closed 610 cases, of which 207 (34 percent) contained substantiated allegations. We wrote 102 letters responding to inquiries received from Congress.

Outcomes

- VA managers imposed 32 administrative sanctions against employees and took 118 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled almost $1.1 million.

Veterans Health Administration

Quality of Patient Care

The responses to Hotline inquiries by VA management officials indicated that 47 allegations regarding deficiencies in the quality of patient care provided by individual facilities were found to have merit and required corrective action. An example follows.

- A VHA review of a veteran's medical records determined that, although his treatment provider, the VAMC, and the VARO were aware of his Hepatitis C end-stage liver disease and his placement on a transplant registry for over 3 years, he was not informed of or referred to the VA transplant program. As a result of these findings, management has authorized the veteran's treatment at a private hospital, including all associated medical expenses. Management has also appointed a transplant coordinator to ensure timely processing of transplant requests.

Ethical Improprieties/Employee Misconduct

The responses to Hotline inquiries by management officials indicated that 17 allegations of ethical improprieties/employee misconduct at individual VA facilities were found to have merit and required corrective action. An example follows.

- A VHA review found an employee, hired under the Outstanding Scholars Program, falsified his employment application and official school transcript to indicate he earned a bachelor's degree when, in fact, he did not. Management proposed the employee's removal from Federal employment and debarment by the Office of Personnel Management.

Time and Attendance

The responses to Hotline inquiries by management officials indicate that 16 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 of a supervisory nurse's compensatory time found significant and unexplained discrepancies between her reported time and evidence of her physical presence at the VAMC. Management proposed the employee be demoted one grade level and withdrew 38 hours of unverified compensatory time. In addition, management counseled the employee's supervisor, who had approved the improper requests, and amended administrative procedures to provide better accountability in accruing compensatory time.

Fiscal Controls

The responses to Hotline inquiries by management officials indicate that five allegations of deficient or improper fiscal controls at individual VA facilities were found to have merit and required corrective action. An example follows.

- A VHA Administrative Board of Investigation substantiated allegations of mismanagement. The board report stated the patient accounts manager required a thorough retraining on fund controls, operating procedures, eligibility requirements, and dealing with people. In addition, the board

recommended the chief of the business office be reoriented to his roles and responsibilities as a manager.

Patient Safety

The responses to Hotline inquiries by management officials indicate that seven allegations of patient safety deficiencies at individual VA facilities were found to have merit and required corrective action. An example follows.

- A VHA review determined a pharmacy error caused a veteran to receive and ingest the wrong medication that lead to his subsequent hospitalization. In response, management assembled a root cause analysis team to investigate the entire process. The pharmacy implemented the team's recommendations and adopted a comprehensive double check system for all prescriptions dispensed from the outpatient clinic.

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. An example follows.

- A VHA review determined a medical center was not properly managing the acquisition and disposition of computer equipment. Management implemented strategies to prepare computer drives for proper disposal, establish better inventory controls and buying practices for spare equipment, and return unused new items to the vendor for credit.

Privacy Act and Health Insurance Portability and Accountability Act

Responses by management indicate that five allegations involve violations of privacy by employees at individual VA facilities had merit and required action. Examples of the issues follow.

- A VHA review concluded there was a violation of a veteran's privacy relating to his HIV status. The information was inappropriately divulged by an employee during a union meeting. The employee was verbally counseled and the staff received training regarding privacy violations.

- A VHA investigation confirmed nurses on a ward of a medical center were calling patients to the nurse's station to administer medications, take vital signs, and administer treatment. Management immediately halted this practice and implemented a range of procedural changes designed to bring nursing staff into patient areas for all treatment and care, and thereby foster better interaction with the patients. Nurse managers are to monitor compliance with the new procedures and will take appropriate disciplinary action as required.

Facilities and Services

The responses to Hotline inquiries by VA management officials indicated that 30 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 found biological waste, chemical waste, and sharps waste in a research laboratory were disposed improperly. Additionally, research animal cages contained

droppings, and equipment was not sanitized. As a result, management arranged for biohazard bags and containers to be disposed appropriately. Animal cages were cleaned and recycled, and equipment was inventoried and assessed for storage.

- A VHA review confirmed a service-connected veteran failed to receive an initial appointment within 30 days of his request. The veteran was provided a primary care appointment. Additionally, the staff was retrained on the importance of scheduling new-service connected veterans within the 30-day timeframe.

Veterans Benefits Administration

Receipt of VA Benefits

The responses to Hotline inquiries by management officials indicate that 29 allegations involving improprieties in the receipt of VA benefits were found to have merit and required corrective action. Examples follow.

- A VBA review found a veteran, claiming to be helpless or nearly helpless and receiving aid and attendance benefits since 1985, was ineligible for benefits since he did not require assistance with his basic needs and was even able to operate a motor vehicle. The VARO discontinued the veteran's benefits and estimated the resulting overpayment at $600,000.

- A VBA field examination and follow-up physical examination revealed a veteran who claimed to be unable to work because of a painful back condition was still agile enough to climb trees, bend backward from the waist to install equipment, and walk briskly. The VARO has proposed to terminate the veteran's rating of unemployability, resulting in a VA savings of $332,883.

- A VBA review determined an 80 percent service-connected veteran receiving 100 percent individual unemployability benefits is gainfully employed and failed to report his employment. The savings from reducing his benefits is $144,000.

Facilities and Services

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

- VBA determined a veteran's rating decision was mailed to the wrong address in error. As a result, the staff involved has been given refresher training about the Privacy Act to help prevent such mistakes.

- VBA determined a veteran did not receive his monthly check after his address had been changed by telephone without his permission. Regional office staff noted in the veteran's file that future telephone requests of this nature will not be accepted, verified his current address, and issued a special back-payment check.

VA Central Office

Cyber Security

The responses to Hotline inquiries by VA management officials indicated that seven allegations regarding cyber security were found to have merit. An example follows:

- A VA Central Office review determined a political solicitation from an approved Web link showed up in a specific search of the official VA Website. Within hours, however, the link was removed from the Web registry and sample documents were no longer accessible through a search of VA's internet site.

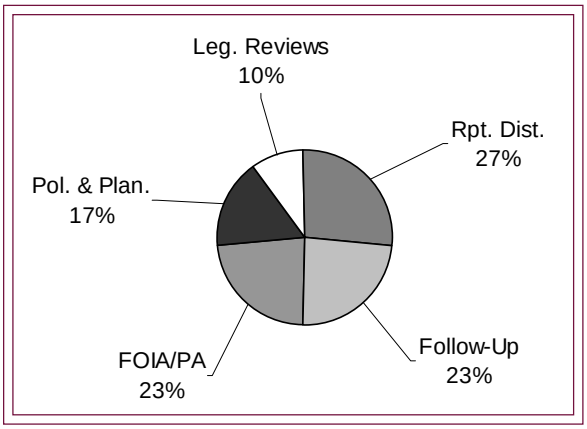
II. OPERATIONAL SUPPORT DIVISION

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; strategic, operational, and performance planning; providing electronic report distribution; and overseeing Inspector General reporting requirements.

Resources

This Division has 10 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 $1.98 billion of actual or potential monetary benefits as of September 30, 2004.

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 corrective actions are implemented by VA management officials. 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 131 reports and 648 recommendations with a monetary benefit of $915 million during this period. As of September 30, 2004, VA had 54 open OIG reports with 366 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, health care 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 175 requests under the FOIA and PA and released 224 audit, investigative, and other OIG reports. Information was totally denied in 9 requests and partially withheld in 77 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, OIG distributes reports through a link to the OIG Web page. Individuals on the distribution list receive a short e-mail describing the report, with a link that takes them 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. This approach also places unrestricted OIG reports on our Web page as soon as they are issued.

We began using this method to distribute our CAP review reports in October 2003 and expanded to include other unrestricted reports in August 2004. During this reporting period a total of 29 CAP reports were released electronically. In addition, six non-CAP reports were released electronically.

Review and Impact of Legislation and Regulations

Operational Support coordinated concurrences on 40 legislative, 40 regulatory, and 78 administrative proposals from the Congress, OMB, 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, reliability 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 electronic databases.

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 and Intranet resources. 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.

Overall Performance

Master Case Index (MCI)

During this reporting period, the MCI application has continued to expand in support of the OIG mission. We are upgrading the MCI infrastructure with hardware and software. We are actively migrating the Oracle database to the newest release of Oracle and redeploying the MCI intranet.

Internet and Electronic FOIA

The Division maintains OIG Websites and posts OIG reports on the Internet. Data files on the OIG Websites were accessed over 1.4 million times by more than 146,000 visitors. OIG reports, vacancy announcements, and other publications accounted for almost 748,000 downloads from our Websites, providing both timely access to OIG customers and cost avoidance in the reduced number of reports printed and mailed. Our support of the OIG's electronic report distribution initiative has resulted in an 116 percent increase (almost 353,000 additional downloads) in reports and other publications downloads from our public Websites.

Information Management, Security, and Coordination

We provided training on the OIG's data and e-mail encryption software as well as the VA's public key infrastructure e-mail encryption system to OIG investigators. We also provided instructions on setting up encrypted data file transfers with other VA staff.

Statistical Support and IT Training

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. For the reporting period, the OIG statistician provided statistical consultation and support for all CAP reviews, and data analysis concerning purchase card use at each facility. We developed and published several online surveys in support of OIG activities.

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 also 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.

Fugitive Felon Matches

As a continuation of the computer match of VA records to state and Federal files, the DAS matched 1,701,745 warrants from the NCIC database, an additional 30,253 from the Washington State Patrol and 29,694 from the New York State Police to more than 10 million records contained in VA benefit system files. We identified 11,025 additional fugitive felons as a result.

Data Mining to Detect Potential Fraud in VA Computer Systems

The DAS took a proactive approach to finding and reporting fraud by developing computer profiles that reflect the known procedures used to defraud the VA. An updated run of the death match program resulted in an additional 1,568 referrals to the Office of Investigations. Total monthly awards for these accounts were $802,818. DAS also extracted duplicate medical payments paid over a 20-month period revealing over $1 million in such payments.

CAP Reviews

The DAS provided technical support and data for all health care reviews focusing on the quality, efficiency, and effectiveness of medical services provided to veterans. The DAS also provided support for CAP reviews on VA benefits that focused on the delivery of monetary benefits to veterans and their dependents. A combined total of over 426 data extracts and reports were produced in support of this activity. An additional 325 reports were produced for teams conducting national health care/audit reviews such as lists of cancelled appointments, cost reports for contract nursing home, and colonoscopies and pathology clinic visits.

Large VA Benefit Payments

DAS staff provided an analysis of all VA "one-time" benefit payments exceeding $10,000. The reports have been incorporated into the information available to CAP teams preparing to review a VARO.

Medical Care Collections Fund

The DAS worked with members of CAP review teams to develop a number of special reports related to patient insurance coverage, recovery of the cost of care from the primary provider of coverage, and analyses of factors such as the reasons care would not be billable.

Assistance to Other Agencies

We provided assistance to the VA police at a facility by providing the total cost of medical care fraudulently obtained by an individual who had stolen the identity of a veteran.

Other Workload

During the reporting period, the DAS completed 147 ad hoc requests for data from other OIG operational elements. Considerable effort was expended in support of the CoreFLS review at the Bay Pines VAMC.

IV. FINANCIAL AND ADMINISTRATIVE SUPPORT DIVISION

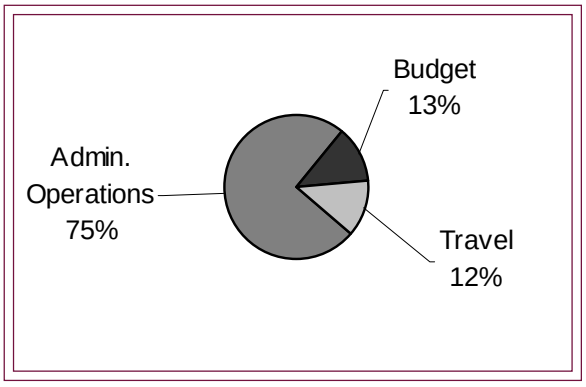
Mission Statement

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 2006 budget submission and materials for associated hearings with VA and the Office of Management and Budget.

Travel

By the nature of our work, OIG personnel travel almost continuously. As a result, we processed 2,234 travel and 12 permanent change of station vouchers.

Administrative Operations

The 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 173 procurement actions, and reviewed and approved monthly the 88 statements received from the OIG's cardholders under the Government's purchase card program.

V. HUMAN RESOURCES MANAGEMENT DIVISION

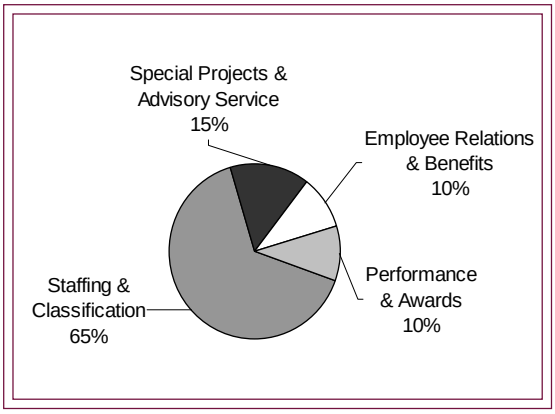
Mission Statement

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

Eight FTE, committed to human resources management and support, currently expend time across the following functional areas.



Overall Performance

Human Resources Management

As of September 30, 2004, the on-board strength is at its highest level in OIG history. During this 6-month period, 29 new employees joined the OIG workforce and 15 departed. The staff processed 142 recruitment and placement actions, processed 400 awards, and enrolled 32 employees in advanced leadership and management development classes.

The 12th Annual OIG awards ceremony took place in April 2004. The Inspector General presented awards for distinguished achievement, exceptional teamwork, outstanding initiative, and sustained superior accomplishment. Each Assistant Inspector General presented awards for the employee of the year and team accomplishment of the year. A total of 57 employees were recognized and an additional 19 employees received quality step increases.

We held an OIG New Employee Orientation Program in April 2004. Over 30 employees attended the 2-day program and learned about OIG organizational values, history, strategic goals, and organizational structure from the senior management staff. A former prisoner of war in Vietnam delivered an inspirational speech on the value of public service to the preservation of freedom in America.

VAOIG New Employee Orientation
City Museum
Washington, DC
April 2004

The OIG succession plan has resulted in the placement of 21 current or recent college graduates under two special hiring programs: the OIG Student Career Experience Program and the OIG Federal Career Intern Program (FCIP).

Seventeen college students are working part-time in our field offices and at the headquarters in a variety of occupational disciplines. The students receive developmental assignments and training in their career fields, and are eligible for permanent placement upon graduation. Four recent college graduates were selected for the OIG FCIP. We provide these employees with sound and systematic training and development during a 2-year internship. Those demonstrating successful performance will be eligible for conversion to permanent appointments.
We replaced the credentials of our Audit, Investigations, and Healthcare Inspections staff with new credentials with enhanced security features. The new credentials include a holographic OIG seal to prevent tampering.

OTHER SIGNIFICANT OIG ACTIVITIES

President's Council on Integrity and Efficiency

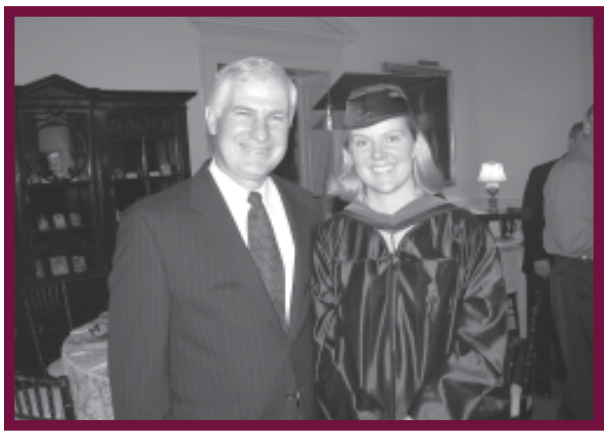
- The OIG Financial Audits Division staff participated in the audit executive committee workgroup on financial statements. The workgroup facilitates communication of financial statement audit issues throughout the Federal community.

- The Director, Information Technology Audit Division, is the subcommittee chair of the Policy Review Committee, IT Security Committee. The Policy Review Committee is chartered with reviewing OMB and National Institute of Standards and Technology publications and to coordinate a consolidated response from the IG community to the publishing organization.

OIG Management Presentations

Inspector General Receives Honorary Doctorate

- Marymount University, located in Arlington, VA, conferred the honorary degree of Doctor of Humane Letters upon the Honorable Richard J. Griffin during its Spring 2004 commencement ceremony at Daughters of the American Revolution Constitution Hall, Washington, DC. Mr. Griffin was recognized for steadfast integrity and leadership in serving our nation's veterans, and honored for exemplary service to our country over a 33-year Federal career. Mr. Griffin received a Masters in Business Administration from Marymount University in 1984. In his remarks to the graduates, Mr. Griffin asked the audience to remember the words of Winston Churchill, "We make a living by what we get; we make a life by what we give."



Inspector General Richard J. Griffin is pictured with OIG Human Resource Analyst, Lisa Stahl, the first OIG co-op student hired into a permanent, full-time position upon her graduation from Marymount University.

Leadership VA 2004 Program

- The Inspector General participated in the "Meet the Leaders" roundtable discussion with the Leadership VA Class of 2004 in Philadelphia. This program is VA's premier leadership development program.

Secret Service Agent Graduation

- The Inspector General gave the commencement address at a Secret Service Special Agent Graduation in Beltsville, MD.

12th Annual Leadership VA Alumni Association Forum

- The Inspector General participated in a panel discussion with other senior VA officials at this

forum in Miami, responding to questions from the VA executives and managers attending.

Annual Conference of Women in Federal Law Enforcement

- The Inspector General participated on a panel of Inspectors General at the annual conference.

System-wide Ongoing Assessment and Review Strategy Consultant Training Conference

- The Director, Los Angeles Healthcare Inspections Regional Office, and an Audit Manager, Seattle Audit Operations Division, made a presentation on CAP reviews and recent findings to VHA employees training as consultants at their conference in Portland, Oregon.

VISN 17 Management

- The Healthcare Inspections staff from the Dallas Regional Office met with VISN 17 employees and provided an overview of CAP and hotline review processes and discussed possible review areas for future CAPs.

VHA Lecture Series on Workers' Compensation Program Issues

- The Project Manager, Central Office Audit Division, and the Office of Investigations Program Director made a presentation on identifying and reporting WCP fraud as part of the monthly lecture series.

Washington Chapter of the Association of Certified Fraud Examiners

- The Director, Central Office Audit Division, and the Project Manager made a presentation on WCP fraud detection at the bi-monthly meeting of the chapter. The presentation included highlights of our audit work over the last several years and our Web-based resources that are available to assist in fraud detection and program management.

VA INFOSEC 2004 Security Conference and VA Information Technology Conference

- The Director, Information Technology Audit Operations Division, made a presentation on the OIG viewpoint of the state of VA security at the national information security conference in Atlanta, and national IT conference in Austin. Over 1,200 VA staff attended the security conference and over 2,000 attended the IT conference.

VISN Chief Financial Officer's (CFO) Conference

- The Program Manager in the Financial Audits Division made a presentation on financial audit issues to the conference attendees.

United American Nurses, AFL-CIO Conference

- The Director, Hotline Division, made a presentation to the United American Nurses, AFL-CIO in Seattle, Washington, on September 21. The Director covered such topics as how to report allegations to the OIG Hotline and what kinds of complaints result in an OIG investigation. The group included 29 nurses, who were interested in learning about the VA OIG Hotline.

Federal Health Care Acquisition Conference

- The Counselor to the Inspector General, and representatives from the OIG's Contract Review and Evaluation Division made three presentations to industry at the conference. The presentations included: (i) how and where to make voluntary disclosures and conducting of self audits; (ii) justification for contracting with affiliates, solicitation provisions, proposal reviews, costs issues, and ongoing issues; and (iii) effects of a Public Law on VA awarded FSS pharmaceutical contracts.

9th Annual Medicare Drug Rebate Conference

- A representative from the OIG's Contract Review and Evaluation Division made a presentation to industry at the conference. The presentation covered the new TRICARE retail pharmacy benefit and the impact on Federal ceiling price calculations.

Office of Acquisition and Materiel Management's Acquisition Forum

- A representative from the OIG's Contract Review and Evaluation Division made a presentation to VA contracting personnel. The presentation covered various aspects of contracting with affiliates for health care resources.

Awards and Special Thanks

Military Order of the Purple Heart Ceremony

- In May 2004, the Inspector General spoke at an award ceremony held in Tampa, FL. Special Agents Mott Heath and William Chirinos each received the National Commander's Law Enforcement Award. Special Agent Mott Heath was responsible for identifying a VA pharmacy technician and a purchasing agent who conspired to divert over 600,000 tablets of hydrocodone and alprazolam from a VA outpatient clinic. Special Agent William Chirinos played a critical role in the successful investigation and prosecution of a high profile false benefits case. The investigation revealed the subject had fraudulently collected over $385,000 in veterans' disability benefits.

American Organization of Nurse Executive

- Verena Briley-Hudson, Director, Chicago Healthcare Inspections Regional Office, was chosen by the American Organization of Nurse Executives (AONE) as one of only 12 nurse leaders to appear on its 2005 Nurse Leader calendar. Nursing Spectrum, a Journal for Nurse Leaders, is producing the calendar. Ten thousand copies of this calendar will be distributed nationwide.

Letter of Appreciation

- Verena Briley-Hudson, Director, Chicago Healthcare Inspections Regional Office, received a letter of thanks from the American Association of Spinal Cord Injury Nurses' Professional Issues Committee chairperson for writing health care-

related legislative alerts which are posted on the Association's web page to assist in keeping members informed about noteworthy issues. Ms. Briley-Hudson has also agreed to accept the challenge of being the new Professional Issues Committee chairperson for a 2-year term.

Training, Exposure, Experience Tournament for Blinded Veterans

- Paula Chapman, Certified Therapeutic Recreation Specialist, Chicago Healthcare Inspections Regional Office, was selected to assist with the Training, Exposure, Experience Tournament for Blinded Veterans hosted by the Iowa City VAMC, and co-sponsored by VA and the Blinded Veterans Association. Participants are U.S. veterans who are legally blind and are VA patients. The tournament accepts 140 participants, and over 270 VA and community volunteers help host this annual event.

VA Wheelchair Games

- Joseph Vallowe, then Director, Operational Support Division, Office of Management and Administration, provided support at the 24th Annual National Veterans Wheelchair Games held at St. Louis, MO, June 15 - 19, 2004. Mr. Vallowe worked as an event photographer.

OIG Congressional Testimony

- The Inspector General, accompanied by the Assistant Inspector General for Healthcare Inspections, testified before the House Committee on Veterans' Affairs. The testimony highlighted OIG efforts during the last year to protect our Nation's veterans and to identify and eliminate criminal activity, waste, abuse, and mismanagement in programs administered by VA.

- The Assistant Inspector General for Auditing testified at a hearing before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs. This was the fourth hearing on VA's third party collections.

24th Annual National Veterans Wheelchair Games
St. Louis, MO
June 2004

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				
03-03207-120 04/2/04	Combined Assessment Program Review of the Togus VA Medical Center Togus, ME	$870,600	$870,600	
04-00009-126 4/13/04	Combined Assessment Program Review of the VA Regional Office Albuquerque, NM	$12,139	$12,139	
04-00403-128 4/14/04	Combined Assessment Program Review of the Northport VA Medical Center Northport, NY			
04-00755-129 4/15/04	Combined Assessment Program Review of the VA Regional Office Salt Lake City, UT	$37,600	$37,600	
04-00356-130 4/16/04	Combined Assessment Program Review of the VA Maryland Health Care System Baltimore, MD			
04-00947-137 4/27/04	Combined Assessment Program Review of the VA Regional Office Winston-Salem, NC	$338,969	$338,969	
03-02729-140 5/6/04	Combined Assessment Program Review of the VA Ann Arbor Healthcare System Ann Arbor, MI			
04-00034-141 5/7/04	Combined Assessment Program Review of the VA Regional Office Detroit, MI	$365,032	$365,032	
04-01096-162 7/2/04	Combined Assessment Program Review of the VA Medical Center Bath, NY	$55,799	$55,799	
04-00928-164 7/15/04	Combined Assessment Program Review of the VA Medical Center Chillicothe, OH	$103,399	$103,399	
04-01345-165 7/15/04	Combined Assessment Program Review of the VA Regional Office Seattle, WA	$527,596	$527,596	
04-00931-166 7/15/04	Combined Assessment Program Review of the VA Medical Center Tuscaloosa, AL	$108,800	$108,800	$270,266
04-00489-167 7/15/04	Combined Assessment Program Review of the Southern Nevada Healthcare System Las Vegas, NV	$13,000	$13,000	

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)				
03-03038-168 7/15/04	Combined Assessment Program Review of the Aleda E. Lutz VA Medical Center Saginaw, MI	$55,234	$55,234	
04-00602-171 7/30/04	Combined Assessment Program Review of the VA Medical Center Battle Creek, MI	$338,732	$338,732	
04-00627-172 7/30/04	Combined Assessment Program Review of the Northampton VA Medical Center Leeds, MA	$19,613	$19,613	$57,000
04-00566-173 8/9/04	Combined Assessment Program Review of the Amarillo VA Medical Care System Amarillo, TX			
04-01456-181 8/13/04	Combined Assessment Program Review of the Carl T. Hayden VA Medical Center Phoenix, AZ	$13,500	$13,500	
04-01946-188 8/27/04	Combined Assessment Program Review of the VA Gulf Coast Health Care System Biloxi, MS			
04-01524-189 8/27/04	Combined Assessment Program Review of the VA Regional Office Lincoln, NE	$393,135	$393,135	
04-00631-190 8/27/04	Combined Assessment Program Review of the VA Medical Center Memphis, TN	$196,000	$196,000	
04-00230-191 8/27/04	Combined Assessment Program Review of the El Paso VA Health Care System El Paso, TX	$3,224	$3,224	
04-00937-196 8/30/04	Combined Assessment Program Review of the VA Chicago Health Care System Chicago, IL	$14,499	$14,499	$146,867
04-01128-201 9/7/04	Combined Assessment Program Review of the Portland VA Medical Center Portland, OR	$715,833	$715,833	
04-00540-208 9/24/04	Combined Assessment Program Review of the VA Medical Center Beckley, WV	$215,094	$215,094	
04-01619-211 9/24/04	Combined Assessment Program Review of the VA Medical Center Erie, PA	$5,773	$5,773	$114,058
04-01863-219 9/28/04	Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center Columbia, SC	$1,496,552	$1,496,552	
04-01016-220 9/29/04	Combined Assessment Program Review of the VA Regional Office Jackson, MS	$1,065,550	$1,065,550	
04-01718-222 9/29/04	Combined Assessment Program Review of the North Florida/South Georgia Veterans Health System	$652,400	$652,400	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
JOINT REVIEW				
04-01371-177 8/11/04	Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)			
INTERNAL AUDITS				
03-01237-132 4/19/04	Management Letter, Audit of VA's Fiscal Years 2003 and 2002 Consolidated Financial Statements General Computer Controls Review at the Austin Automation Center			
03-01237-133 4/19/04	Management Letter, Audit of VA's Fiscal Years 2003 and 2002 Consolidated Financial Statements General Computer Controls Review at the Philadelphia Information Technology Center and Insurance Center			
03-01237-134 4/19/04	Management Letter, Audit of VA's Fiscal Years 2003 and 2002 Consolidated Financial Statements General Computer Controls Review at the Hines Information Technology Center			
02-03056-182 8/13/04	Follow-Up Audit of Department of Veterans Affairs Workers' Compensation Program Cost	$696,200,000	$696,200,000	
03-01237-192 8/26/04	Management Letter, Audit of VA's Fiscal Years 2003 and 2002 Consolidated Financial Statements Compensation and Pension Application Follow-Up Review			
03-01237-193 8/26/04	Management Letter, Audit of VA's Fiscal Years 2003 and 2002 Consolidated Financial Statements Financial Management System Application Follow-Up Review			
03-01237-194 8/26/04	Management Letter, Audit of VA's Fiscal Years 2003 and 2002 Consolidated Financial Statements Personnel and Accounting Integrated Data Application Follow-Up Review			
03-01237-195 8/26/04	Management Letter, Audit of VA's Fiscal Years 2003 and 2002 Consolidated Financial Statements Loan Guaranty System Application Follow-Up 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)				
03-01237-198 8/30/04	Management Letter, Audit of VA's Fiscal Years 2003 and 2002 Consolidated Financial Statements Integrated Funds Distribution, Control Point Activity, Accounting and Procurement Application Review			
OTHER OFFICE OF AUDIT REVIEWS				
02-01481-135 4/26/04	Evaluation of the Department of Veterans Affairs Government Purchase Card Program			
04-01757-205 9/10/04	Evaluation of Allegation of Physician Time and Attendance Abuse at the Salem VA Medical Center Salem, VA			
04-00310-212 9/27/04	Evaluation of Veterans Health Administration's Transitional Pharmacy Benefit			
CONTRACT PREAWARD REVIEWS				
04-00279-121 4/1/04	Review of Federal Supply Schedule Proposal Submitted by Novo Nordisk Pharmaceuticals, Incorporated, Under Solicitation Number M5-Q50A-03	$960,770	$960,770	
04-00854-122 4/2/04	Review of Proposal Submitted by Indiana University Under Solicitation Number 583-48-03 for Vascular Surgeon Services at Richard L. Roudebush VA Medical Center	$1,775,424	$1,775,424	
04-00899-123 4/2/04	Review of Proposal Submitted by Indiana University Under Solicitation Number 583-47-03 for Vascular Technologist Services at Richard L. Roudebush VA Medical Center	$261,926	$261,926	
04-00066-124 4/2/04	Review of Federal Supply Schedule Proposal Submitted by Upsher-Smith Laboratories, Inc., Under Solicitation Number M5-Q50A-03	$20,687,256	$20,687,256	
04-00459-125 4/5/04	Review of Federal Supply Schedule Proposal Submitted by UDL Laboratories Under Solicitation Number M5-Q50A-03			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT PREAWARD REVIEWS (Cont'd)				
03-03056-127 4/8/04	Review of Federal Supply Schedule Proposal Submitted by Bristol-Myers Squibb Company US Medicines Group Under Solicitation Number M5-Q50A-03	$24,492,896	$24,492,896	
04-00385-131 4/15/04	Review of Federal Supply Schedule Proposal Submitted by Baxter Healthcare Corporation, Medication Delivery, Under Solicitation Number M5-Q50A-03			
04-00573-142 5/6/04	Review of Federal Supply Schedule Proposal Submitted by Mallinckrodt, Inc., Under Solicitation Number M5-Q50A-03	$2,519,792	$2,519,792	
04-01413-143 5/10/04	Review of Federal Supply Schedule Proposal Submitted by Purdue Pharma L.P. Under Solicitation Number M5-Q50A-03			
04-00415-146 5/11/04	Review of Federal Supply Schedule Proposal Submitted by Genzyme Corporation Under Solicitation Number M5-Q50A-03			
04-00879-147 5/14/04	Review of Federal Supply Schedule Proposal Submitted by Organon USA Inc., Under Solicitation Number M5-Q50A-03	$3,849,544	$3,849,544	
04-00574-152 6/1/04	Review of Federal Supply Schedule Proposal Submitted by Aventis Pharmaceuticals, Inc., Under Solicitation Number M5-Q50A-03	$306,492	$306,492	
04-00458-156 6/14/04	Review of Federal Supply Schedule Proposal Submitted by Medimmune, Inc., Under Solicitation Number M5-Q50A-03			
04-01381-158 6/17/04	Review of Proposal Submitted by University of Nevada - Reno Under Solicitation Number 261-0065-04 for Medical Officer of the Day Services at VA Sierra Nevada Health Care System	$17,376	$17,376	
04-00280-159 6/23/04	Review of Federal Supply Schedule Proposal Submitted by Baxter Healthcare Corporation Under Solicitation Number M5-Q50A-03			
04-00416-160 6/28/04	Review of Federal Supply Schedule Proposal Submitted by Baxter Healthcare Corp. Anesthesia and Critical Care Under Solicitation Number M5-Q50A-03	$133,402	$133,402	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT PREAWARD REVIEWS (Cont'd)				
04-00569-161 6/30/04	Review of Federal Supply Schedule Proposal Submitted by Solvay Pharmaceuticals, Inc., Under Solicitation Number M5-Q50A-03	$9,745,556	$9,745,556	
04-00865-157 7/6/04	Review of Proposal Submitted by New York University Under Solicitation Number RFQ 10N3-273-03 for Radiology Services at New York Harbor Health Care System			
04-01304-163 7/6/04	Review of Federal Supply Schedule Proposal Submitted by Abbott Laboratories, Inc., Under Solicitation Number RFP-797-FSS-03-0001	$3,940,030	$3,940,030	
04-00191-174 8/9/04	Review of Federal Supply Schedule Proposal Submitted by Amersham Health Under Solicitation Number M5-Q50A-03			
04-00198-178 8/10/04	Review of Federal Supply Schedule Proposal Submitted by Ethex Corporation Under Solicitation Number M5-Q50A-03	$26,016,920	$26,016,920	
04-02273-179 8/10/04	Review of Federal Supply Schedule Proposal Submitted by Procter & Gamble Pharmaceuticals, Inc., Under Solicitation Number M5-Q50A-03			
04-01874-180 8/10/04	Review of Federal Supply Schedule Proposal Submitted by Novartis Pharmaceuticals Corporation Under Solicitation Number M5-Q50A-03	$647,688	$647,688	
04-00651-176 8/13/04	Review of Federal Supply Schedule Proposal Submitted by Forest Laboratories, Inc., Under Solicitation Number M5-Q50A-03	$2,706,840	$2,706,840	
04-01414-185 8/16/04	Review of Federal Supply Schedule Proposal Submitted by Berlex Laboratories, Inc., Under Solicitation Number M5-Q50A-03	$969,469	$969,469	
04-00863-197 8/26/04	Review of Federal Supply Schedule Proposal Submitted by AGFA Corporation Under Solicitation Number RFP-797-655A-99-0001	$2,344,651	$2,344,651	
04-01042-199 8/30/04	Review of Federal Supply Schedule Proposal Submitted by Allergan Sales, LLC Under Solicitation Number M5-Q50A-03	$5,569,878	$5,569,878	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT PREAWARD REVIEWS (Cont'd)				
04-02200-200 8/30/04	Review of Federal Supply Schedule Proposal Submitted by Serono, Inc., Under Solicitation Number M5-Q50A-03			
04-02198-186 9/2/04	Review of Federal Supply Schedule Proposal Submitted by E. Fougera & Company, Division of Altana, Inc., Under Solicitation Number M5-Q50A-03	$2,414,110	$2,414,110	
04-01303-202 9/7/04	Review of Federal Supply Schedule Proposal Submitted by Bayer Healthcare LCC, Diagnostics Division, Under Solicitation Number RFP-797-FSS-03-0001			
04-02555-207 9/16/04	Review of Federal Supply Schedule Proposal Submitted by Shire US Incorporated Under Solicitation Number M5-Q50A-03			
04-01436-209 9/21/04	Review of Federal Supply Schedule Proposal Submitted by Kremers Urban, Inc., Under Solicitation Number M5-Q50A-03	$716,716	$716,716	
04-02041-210 9/21/04	Review of Federal Supply Schedule Proposal Submitted by Amgen Inc., Under Solicitation Number M5-Q50A-03	$633,393	$633,393	
04-01962-213 9/22/04	Review of Federal Supply Schedule Proposal Submitted by Pliva, Inc., Under Solicitation Number M5-Q50A-03	$10,311,315	$10,311,315	
04-02702-214 9/22/04	Review of Proposal Submitted by the University of Pittsburgh Physicians Under Solicitation Number 244-04-00260 for Anesthesiology Physician Services at the Department of Veterans Affairs Pittsburgh Health Care System	$162,651	$162,651	
04-01762-215 9/22/04	Review of Federal Supply Schedule Proposal Submitted by Eli Lilly and Company Under Solicitation Number M5-Q50A-03			
04-01539-217 9/22/04	Review of Federal Supply Schedule Proposal Submitted by Bracco Diagnostics, Inc., Under Solicitation Number M5-Q50A-03			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT PREAWARD REVIEWS (Cont'd)				
04-02503-223 9/28/04	Review of Proposal Submitted by the University of Pittsburgh Physicians Under Solicitation Number 244-04-00305 for Critical Care Medicine Physician Services at the Department of Veterans Affairs Pittsburgh Health Care System	$54,106	$54,106	
04-02772-224 9/28/04	Review of Proposal Submitted by the University of Miami, School of Medicine, Under Solicitation Number 546-69-04 for Otolaryngology Services at the Department of Veterans Affairs Medical Center, Miami	$281,305	$281,305	
CONTRACT POSTAWARD REVIEWS				
04-01410-119 4/1/04	Verification of Johnson & Johnson Health Care Systems, Inc. - Alza Products' Self-Audit Under Federal Supply Contract Number V797P-5215x			$1,996
04-01274-136 4/22/04	Verification of UCB Pharma, Inc.'s Self-Audit Under Federal Supply Schedule Contract Number V797P-5404x			$44,734
04-01408-144 5/11/04	Verification of Aventis Pharmaceuticals' Self-Audit Under Federal Supply Schedule Contract Number V797P-5155x			$142,420
04-01409-145 5/11/04	Verification of Johnson & Johnson Health Care Systems, Inc., - Ortho-McNeil's Self-Audit Under Federal Supply Schedule Contract Number V797P-5438x			$39,722
03-02672-148 5/14/04	Review of Terumo Medical Corporation's Self-Audit of Federal Supply Schedule Contract V797-3741k			$32,531
02-01320-149 5/17/04	Settlement Agreement with a Medical Supply Manufacturer			$183,000
04-02586-170 7/15/04	Verification of Bausch & Lomb's Self-Audit Under Federal Supply Schedule Contract Number V797P-5279x			$84
04-00572-204 9/9/04	Review of Proposed Settlement by Ivax Pharmaceuticals, Inc., Under Federal Supply Schedule Contract Number V797P-5305x			$103,786

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT POSTAWARD REVIEWS (Cont'd)				
04-03094-216 9/22/04	Verification of Bertek Pharmaceuticals Inc.'s Self-Audit Under Federal Supply Schedule Contract Number V797P-5150X			$67,718
03-03021-218 9/27/04	Review of Forest Laboratories, Inc.'s Billings Under Federal Supply Schedule Contract Number V797P-5346x			$489,591
HEALTHCARE INSPECTIONS				
03-00391-138 5/3/04	Healthcare Inspection, Veterans Health Administration's Community Residential Care Program			
02-01747-139 5/3/04	Healthcare Inspection, Healthcare Program Evaluation Veterans Health Administration's Management of Violent Patients			
03-02110-150 5/20/04	Healthcare Inspection, Quality of Care Issues, Washington DC Veterans Affairs Medical Center			
04-00037-151 5/28/04	Healthcare Inspection, Inspection of Patient Care and Environmental Issues on the Spinal Cord Injury Unit, VA Medical Center San Juan, PR			
04-01371-153 6/4/04	Healthcare Inspection, Review of Quality of Care and Communication Issues, Department of Veterans Affairs Medical Center Bay Pines, FL			
03-00312-169 7/14/04	Summary Report, Healthcare Inspection, Evaluation of Quality Management in Veterans Health Administration Facilities, Fiscal Year 2003			
04-00275-175 8/6/04	Healthcare Inspection, Allegations of Abuse of Power and Increased Morbidity and Mortality, Department of Surgery, VA Medical Center Memphis, TN			
03-00079-183 8/13/04	Healthcare Inspection, Evaluation of Nurse Staffing in Veterans Health Administration Facilities	$42,448,300	$42,448,300	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
HEALTHCARE INSPECTIONS (Cont'd)				
04-00225-184 8/13/04	Healthcare Inspection, Patient Travel and Contract Transportation Deficiencies, VA Medical Center Augusta, GA			
01-00637-203 9/9/04	Healthcare Inspection, Controlled Substances Management Issues, VA San Diego Healthcare System San Diego, CA			
ADMINISTRATIVE INVESTIGATIONS				
03-02592-154 6/21/04	Administrative Investigation, Physician Time and Attendance Issue, VA Greater Los Angeles Health Care System West Los Angeles, CA			
03-02607-155 7/29/04	Administrative Investigation, Physician Time and Attendance Issue, VA Maryland Health Care System Baltimore, MD			
04-00075-187 8/23/04	Administrative Investigation, Misuse of Funds Issue, Office of Cyber and Information Security, VA Central Office and Martinsburg, WV			
04-01028-206 9/14/04	Administrative Investigation, Preferential Treatment, VA Medical Center Battle Creek, MI			
TOTAL	**105 Reports**	**$867,785,879**	**$867,785,879**	**$1,693,773**

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 its 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 following chart lists 62 unimplemented OIG reports by VA. It also identifies 5 unimplemented reports and recommendations issued over 1 year ago (September 30, 2003, and earlier).

Unimplemented OIG Reports and Recommendations

VA Office	Total		Issued 9/30/03, and Earlier	
	Repts	Recoms	Repts	Recoms
VHA	47	284	4	33
VBA	4	13	1	5
OI&T	4	32	0	0
OM	4	17	0	0
OHRA	2	17	0	0
OPPP	1	3	0	0
Total	**62***	**366**	**5**	**38**

* There are 54 total unimplemented reports. We have listed 62 reports because six reports have actions for two or more offices.

Office of Information and Technology (OI&T)
Office of Management (OM)
Office of Human Resources and Administration (OHRA)
Office of Policy, Planning, and Preparedness (OPPP)

The OIG is particularly concerned with one report on VBA operations (issued in July 2000) and one report on VHA operations (issued in March 2002) with recommendations that still remain open. The following information provides a summary of reports over 1 year old with open recommendations.

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 an 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. Take steps necessary to make use of Social Security Numbers (SSNs) as employee identification numbers, and tie BDN access to SSNs.
5. Ensure perpetual BDN transaction files are maintained that include a unique user identification number identifying the employees associated with the recorded transactions.

Status:

1 and 2. As the Modern Award Processing system is designed, this control will be incorporated. Beta testing of the system began in March 2004. This control will be implemented in the final stages of deployment that is scheduled for completion in December 2005.

3. The validation to ensure outstanding defects impeding the 100 percent use of the Rating Board Automation 2000 application is expected to be completed in November 2005. Upon conclusion, VBA will determine the feasibility and schedule for the retirement of the old application.

4 and 5. VBA created a perpetual user logon history reference table in the corporate database that will perpetually list SSNs, user identifications, and station numbers. The table will be operational in November 2004.

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Veterans Health Administration

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 managers, 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 providing professional oversight of 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: In March 2002, the VA Deputy Secretary requested the VA staff to issue a joint report by September 30, 2002, certifying that all the OIG recommendations had been completed. However, as of September 30, 2004, 15 of 16 recommendations remain unimplemented. Most of the report's recommendations were made to the Under Secretary for Health; however, several recommendations required joint efforts on the part of VHA and the Office of Security and Law Enforcement. During this semiannual period, the Office of Security and Law Enforcement completed their actions by revising two security publications. Also, VHA issued handbooks for control of hazardous agents in VA research laboratories, and for pathology and laboratory medicine biosecurity and biosafety.

VHA plans to issue research and clinical checklists so facilities can reassess the criteria and implement the requirements in the recently issued publications. VHA plans to submit a consolidated certification to the OIG later this year that shows all VAMC directors certify implementation of the directives and security requirements. The purpose of the certification requirement is to document compliance with the directives and provide assurance that the intent of the OIG recommendations to address all the security and control vulnerabilities presented in the report have been addressed and corrected at each facility. In September 2004, the Under Secretary for Health committed to the VA Deputy Secretary that VHA will complete certification of guidance by December 31, 2004.

A VHA-specific training program is being developed that will reflect requirements in the new research laboratories handbook. VHA is also developing a Web-based educational program that outlines security training requirements that will be available through the Intranet in late January 2005. VHA will also develop procedures to forward requests for research articles to the facility Freedom of Information Act officer. VHA initiated a program to spend more than $2 million to upgrade laboratory security in February 2002. Of the 64 research sites identified as needing upgrades, 62 sites have been funded for a total of $2.35 million. Funding for the remaining two sites will be distributed in the 1st quarter, FY 2005.

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Report: *Healthcare Inspection, Patient Care Issues, Department of Veterans Affairs Hudson Valley Health Care System, Franklin Delano Roosevelt Campus, Montrose, NY, 02-02374-08, 10/18/02*

Recommendation:

1. The VISN Director should ensure that the VA Hudson Valley Health Care System Director brings the Franklin Delano Roosevelt campus Residential Care Program into compliance with VHA policy by ensuring that all VA-sponsored homes meet all State and local requirements.

Status: As of September 30, 2004, there are 45 veterans residing in 7 unlicensed community residential care homes, as compared to 182 veterans in 28 unlicensed homes on October 1, 2002. The VA Hudson Valley Health Care System continues facilitating the licensure process of the homes by working closely with the VA Central Office program office (VHA Chief Consultant for Geriatrics and Extended Care); the New

York State Department of Health and Office of Child and Family Services; and the VA-sponsored homes. The homes are inspected regularly and provisions are in place for immediately relocating the veterans from a home if a home fails to meet inspection requirements. The veterans will be relocated should a home fail to demonstrate a good faith effort in the licensure process. The Health Care System anticipates that all homes will be licensed by the end of April 2005.

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Report: *Healthcare Inspection, Evaluation of the VHA's Contract Community Nursing Home (CNH) Program, 02-00972-44, 12/31/02*

Recommendations: The Under Secretary for Health needs to ensure that:

1. VHA medical facility managers devote the necessary resources to adequately administer the CNH program.
2. VHA medical facility managers emphasize the need for CNH review teams to access and critically analyze external reports of incidents of patient abuse, neglect, and exploitation, and to increase their efforts to collaborate with state ombudsman officials.
3. Coordinate efforts with the Under Secretary for Benefits to determine how VHA CNH managers and VBA fiduciary and field examination employees can most effectively complement each other and share information such as medical record competency notes, on-line survey certification and reporting data, and VBA reports of adverse conditions, to protect the financial interests of veterans receiving health care and VA-derived benefits.

Status: As of September 30, 2004, 3 of 11 recommendations remain unimplemented pending actions by the VHA Chief Consultant for Geriatrics and Extended Care. The revised VHA handbook on CNH oversight was published in June 2004. VHA needs to finalize new performance indicators; upgrade the CNH website from the prototype to a finalized site; demonstrate that community health nurses and social workers are visiting veterans in CNHs per the frequency established in the CNH handbook; and finalize the implementation plan/coordinated efforts on how VHA CNH and VBA fiduciary and field examination employees can most effectively complement each other and share information. Completion of all the actions is expected by March 2005.

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Report: *Audit of VHA's Part-Time Physician Time and Attendance, 02-01339-85, 4/23/03*

Recommendation 1: To improve physician timekeeping, we recommend that the Under Secretary for Health:

a. 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, and recommend statutory or regulatory changes needed to implement the reforms and publish appropriate policy and guidance.
b. Establish performance monitors to measure VISN and VAMC enforcement of physician time and attendance.
c. Ensure desk audits are conducted of timekeeping functions.
d. Provide continuing timekeeping education to supervisors, physicians, and timekeepers.
e. Require VAMC managers to certify compliance with applicable policies and procedures to the Deputy Under Secretary for Operations and Management annually.

f. Hold VHA managers accountable for successful implementation of time and attendance requirements.
g. Evaluate appropriate technological solutions that will facilitate physician timekeeping.
h. Develop comprehensive guidance for VAMCs to use when conducting desk audits.
i. Establish appropriate training modules, making best use of technological solutions, for training VHA managers, VA physicians, and timekeepers in timekeeping requirements, responsibilities, and procedures.

Recommendation 2: To better align physician staffing with patient care workload, we recommend that the Under Secretary for Health:

a. 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.
b. 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 medical center.
c. 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.
d. 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.
e. 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.

Status: As of September 30, 2004, 14 of 16 recommendations remain unimplemented pending actions by a number of VHA staff offices. VHA now conducts a monthly random sample of the part-time physicians at each facility to verify the presence of these physicians either through electronic means or by direct physical verification. If any discrepancies are identified, appropriate actions are taken locally. In addition, the issue of part-time physician time and attendance is discussed at the quarterly performance reviews with the network directors. VA has also developed revised policies and procedures that will enable it to more easily meet patient care requirements and schedule physicians in a manner that is more consistent with their practice patterns. The policies and procedures are being paired with modifications to VA's electronic time and attendance (ETA) system. The changes to VA directives and handbooks 5005, 5007, and 5011 have been finalized, but put on hold pending completion of modifications to ETA. Anticipated completion date for the ETA modifications is May 2005.

A VHA workgroup was charged to review the activities of those facilities noted in the OIG report who conducted acceptable desk audits and prepare guidance for use by all facilities. VHA will collaborate with the Office of Financial Management to develop comprehensive guidance for timekeepers. VHA is also developing computer based training for part-time physicians, supervisors, and timekeepers. However, we were not provided planned completion dates.

In July 2004, VHA issued a directive on guidance on primary care panel size that requires VHA primary care practices to establish maximum panel sizes for all primary care providers. A VHA advisory group submitted to the Under Secretary for Health an initial study of physician productivity in the specialty areas of cardiology, ophthalmology, and urology. The group considered several possible productivity models

including the United States Army Medical Command, Army Automated Staffing Assessment Model. VHA will need to do significant software engineering to automate the data necessary to bring the specialty care physician productivity project to fruition. VA continues to work on developing a productivity model for specialty care providers with a planned completion of December 2005.

A draft directive on staffing guidelines for VHA health care providers, including nurses, is in the concurrence process, and it states there is no management information system available that would support nationwide standardized staffing plans for health care providers. VHA anticipates that a system for the collection and analysis of this information will be in place by September 2009.

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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	53
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-52
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-52
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	73 (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	82 (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	63 to 72 (App. A)
Section 5 (a) (7)	Summary of each particularly significant report	i to viii
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	83 (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	84 (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	82 (App. C)
Section 5 (a) (11)	Significant revised management decisions	82 (App. C)
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	82 (App. C)
Section 5 (a) (13)	Information described under section 5(b) of the Federal Financial Management Improvement Act of 1996 (Public Law 104-208)	82 (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. VA began operational testing of a new integrated financial management and logistics system (CoreFLS) on October 6, 2003, at three VA facilities. VA planned to expand operational testing to several other facilities during the fiscal year. However, due to deployment and information technology security issues, further implementation of the system was halted. VA is currently evaluating how it will proceed with the system development effort. At the time it was halted, the project was under the VA Chief Financial Officer. Subsequently, the project has been transferred to the VA Chief Information Officer.

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 OIG reports unresolved for over 6 months.

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 3/31/04	0	$0
Issued during reporting period	14	$1.7
Total Inventory This Period	**14**	**$1.7**
Management decision during reporting period		
Disallowed costs (agreed to by management)	14	$1.7
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Period	**14**	**$1.7**
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 3/31/04	32	$530.3
Issued during reporting period	51	867.8
Total inventory this period	**83**	$1,398.1
Mangement decisions during reporting period		
Agreed to by management	78	$1,383.9
Not agreed to by management	5	$14.2
Total Management Decisions This Period	**83**	**$1,398.1**
Total Carried Over to Next Period	**0**	**$0**

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.

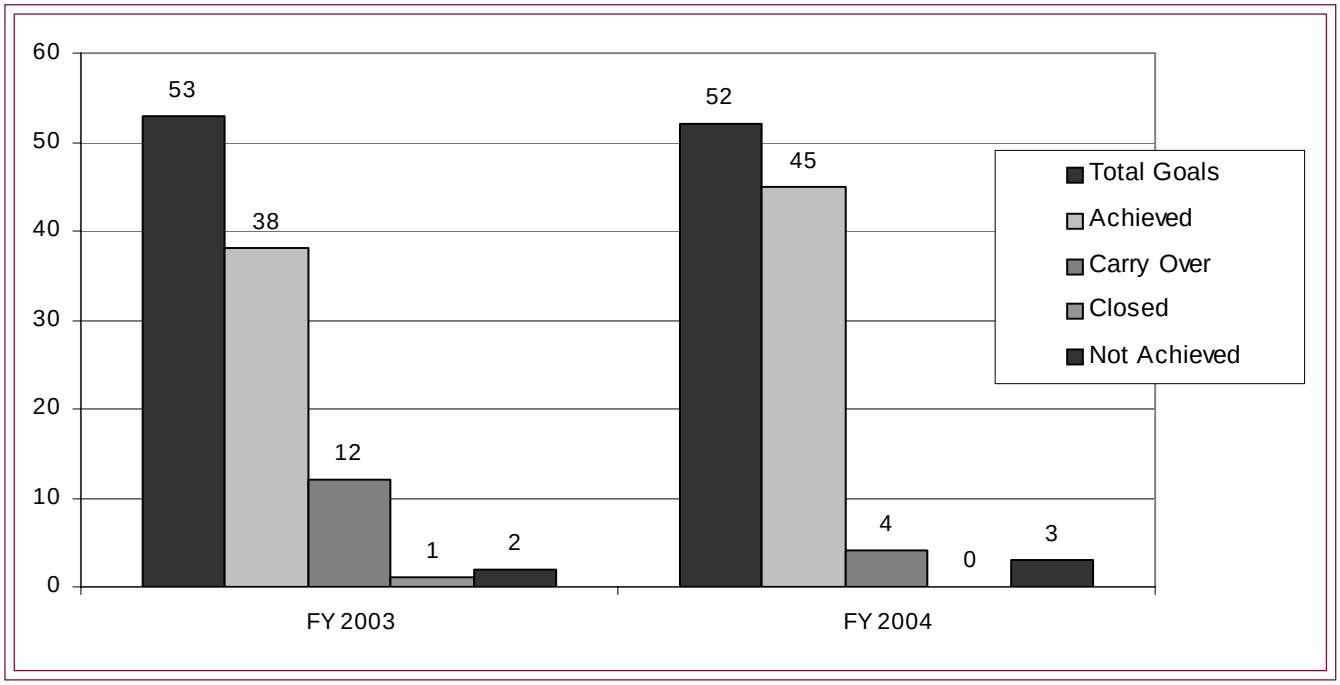
APPENDIX D

VA OIG PERFORMANCE REPORT FY 2005

Overview of FY 2004 Accomplishments

Presented here are the results of our efforts in FY 2004 against the planned goals. Our performance goals and results were linked to the OIG Strategic Plan 2001-2006. Overall, a total of 52 annual performance goals were planned; we achieved 45 (87 percent). Four goals were carried over to FY 2005 and three goals were not achieved due to competing demands on resources. The percent of FY 2004 goal accomplishments represent an increase of 15 percent over the FY 2003 goal accomplishment rate. The chart below illustrates our increased performance levels.

Annual Goals Accomplished



The OIG focuses much of its oversight efforts on systemic issues having the potential for improving VA programs; detecting and deterring VA's criminal activity, waste, and mismanagement; and enhancing overall productivity. Details of OIG accomplishments covering the second 6 months of this fiscal year can be found in the earlier chapters of this report. Details of the accomplishments during the first half of the fiscal year can be found in volume 51 of our semiannual report, dated March 31, 2004.

The following charts reflect the OIG's achievements in FY 2004. We define each strategic goal and list projects by OIG component. The Offices of Investigations, Audit, and Healthcare Inspections accomplished goals through collaborative efforts.

GOAL: Health Care Delivery

Improve veterans' access to high quality and safe health care by identifying opportunities to improve the management and efficiency of VA's health care delivery systems; and by detecting, investigating, and deterring fraud and other criminal activity.

Office of Investigations

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
1	Initiate fraud investigations in the VA health care system including instances of fraud in construction, claims for medical benefits or unauthorized medical care, workers' compensation, and beneficiary travel	Evaluate referrals and initiate appropriate investigations in these areas	316	✓
2	Initiate employee misconduct investigations in the VA health care system including instances of patient abuse, conflicts of interest, resource misuse, travel abuse, and misconduct regarding official time on the job and corresponding timekeeping	Evaluate referrals and initiate appropriate investigations in these areas	174	✓
3	Initiate pharmaceutical investigations involving instances of theft or diversion by both employees and non-employees	Evaluate referrals and initiate appropriate investigations in these areas	85	✓
4	Initiate joint investigative cases with the VA Police relating to crimes committed by VA employees, patients, and visitors in order to ensure the safety of VA medical facilities	Evaluate referrals and initiate appropriate investigations in these areas	225	✓
5	Increase employee consciousness regarding the indicators of fraud and the procedures for referral of matters of criminal conduct to the OIG by conducting briefings for VA employees during visits to VA medical facilities	Conduct 150 briefings	173	✓
6	Conduct a match of verified death data with pharmacy records to identify drug diversion, generate criminal investigations, and recover VHA assets	Evaluate data and initiate appropriate investigations	Not complete due to competing demands on resources	

Office of Healthcare Inspections

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
1	Conduct independent inspections of Hotline complaints and allegations involving patient care and services	Complete 12 Hotline cases	27	✓

Office of Healthcare Inspections

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
2	Conduct oversight reviews of work performed by the Office of the Medical Inspector	Review all OMI draft reports	5	✓
3	Conduct proactive CAP reviews of the management of services provided to veterans and eligible beneficiaries at VA medical facilities, with emphasis on predefined pulse points, and follow-up on VHA's response to previous OIG recommendations to strengthen security, access, inventory, and oversight requirements and procedures for safeguarding all high-risk or sensitive materials or agents used in VA research facilities	Participate in 40 health care CAP reviews	40	✓
4	Analyze the evaluation of VHA's compliance with Office of Research and Development's instructions for controlling and better monitoring human subjects during clinical research trials	Issue the report	Report issued	✓
5	Review security over VA potable and waste water systems, and the degree of VA coordination with EPA concerning those systems	Issue the report	Report issued	✓
6	Complete the inspection of VHA's homemaker/home health aid program	Issue the report	Report issued	✓
7	Evaluate VHA's community residential care program	Complete the analysis and begin drafting the report	Report issued	✓
8	Complete the evaluation of VHA's procedures for responding to and managing patients who become violent	Issue the report	Report issued	✓
9	Analyze the focused areas emphasized during CAP reviews at VA medical facilities and provide input for the consolidated summary report detailing the findings and recommended actions to improve health care operations	Complete analysis and provide information for the consolidated CAP report	Analysis completed and information provided	✓
10	Complete inspection of VHA nurse staffing patterns and planning practices	Issue the report	Report issued	✓
11	Analyze feeding and aspiration controls and care provided at VA facilities	Initiate the review	Review initiated	✓

Office of Audit

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
1	Complete the evaluation to assess the effectiveness of VHA's Community Based Outpatient Clinic (CBOC) planning process and management controls	Issue the report	Postponed due to competing demands	Carried over to FY 2005
2	Conduct proactive CAP reviews of the management of services provided to veterans and eligible beneficiaries at VA medical facilities with emphasis on predefined pulse points	Participate in 40 health care CAP reviews	Participated in 40 CAP reviews	✓
3	Analyze the pulse-points emphasized during CAP reviews at VA medical facilities provide input for consolidated summary reporting addressing findings and recommended actions to improve health care operations, and identify and evaluate emerging issues	Complete analysis and issue consolidated CAP report	Consolidated reports issued	✓
4	Audit VHA's report on capacity for specialized medical treatments	Issue the report	Report issued	✓
5	Audit VHA's report on expenditures of the National Drug Control Program (Attestation of VA's detailed accounting submission)	Issue the report	Report issued	✓
6	Complete a special review of part -time physicians' time and attendance issues	Issue the report	Report issued	✓

GOAL: BENEFITS PROCESSING

Improve the delivery of benefits and services by identifying opportunities to improve the quality, timeliness, and accuracy of benefits processing; and reduce fraud in the delivery of benefits through proactive and targeted investigative efforts.

Office of Investigations

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
1	Initiate investigations involving instances of employee or beneficiary fraud	Evaluate referrals and initiate appropriate investigations in these areas	397	✓
2	Initiate investigations involving instances of employee misconduct in the management, delivery, and processing of benefits and services including theft of government property, embezzlement of VA funds, misuse of appropriated funds, and resource misuse	Evaluate referrals and initiate appropriate investigations in these areas	37	✓

Office of Investigations

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
3	Initiate investigations involving instances of fraud in the Loan Guaranty program	Evaluate referrals and initiate appropriate investigations in these areas	10	✓
4	Increase employee consciousness regarding the indicators of fraud and the procedures for referral of matters of criminal conduct to the OIG by conducting briefings for VA employees during visits to VA regional offices	Conduct 40 briefings	85	✓
5	Complete fugitive felon data matching and sharing agreements with other law enforcement organizations	Complete 4 new agreements	4	✓
6	Conduct computer matches between fugitive felon data provided by law enforcement organizations and VA record systems	Complete 10 computer matches	10	✓
7	Complete the proactive investigation project involving the payment of VA benefits to veterans living in Puerto Rico in order to identify cases of fraudulent receipt of VA funds	Complete the investigation project	Project completed	✓
8	Conduct a review of the Tuition Assistance Top-Up Program to identify potential fraud	Complete the review of one VBA Educational Regional Processing Office	Review completed	✓

Office of Audit

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
1	Complete the evaluation to determine the reasonableness of VBA rating decisions made on claims of current and former employees	Issue the report	Postponed due to competing demands	Carried over to FY 2005
2	Conduct proactive CAP reviews of claims processing and services provided to veterans and eligible beneficiaries at VAROs	Conduct 12 benefit CAP reviews	12	✓
3	Analyze results of CAP reviews at VAROs and prepare a summary report detailing systemic weaknesses, significant findings, and recommended actions needed to improve operations	Issue the report	Report issued	✓

GOAL: FINANCIAL MANAGEMENT SYSTEMS

Assist VA in achieving its financial management mission of providing all VA activities with accurate, reliable, and timely information for sound oversight and decision making; and identify opportunities to improve the quality, management, and efficiency of VA's financial management systems.

Office of Investigations

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
1	Initiate investigations involving instances of fraud and mismanagement occurring in VA's financial management activities and systems	Evaluate referrals and initiate appropriate financial investigations	39	✓

Office of Audit

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
1	Monitor the contractor's audit of VA's FY 2003 Enterprise Fund financial statement	Ensure proper completion of the required annual audit	Audit completed	✓
2	Monitor the contractor's audit of the FY 2003 Consolidated Financial Statement (CFS) as required by the CFO Act of 1990 and the Government Management Reform Act of 1996	Ensure proper completion of the required annual audit	Audit completed	✓
3	Complete the follow-up audit of VA's Workers' Compensation Program	Issue the report	Report issued	✓
4	Report on the promptness of VA's payments for water/sewer services for VA's Washington, DC, facilities	Issue the report	Report in draft	
5	Issue a new statement of work (SOW) to contract for FY 2004 CFS audit	Issue SOW	Issued	✓

GOAL: PROCUREMENT PRACTICES

Identify opportunities to enhance the effectiveness and efficiency of VA's acquisition program in meeting user needs and ensuring the best possible price, and help eliminate opportunities to commit fraud and other illegal acts in the procurement process by investigating and prosecuting criminal activity to the fullest extent of the law.

Office of Investigations

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
1	Initiate investigations involving instances of fraud and mismanagement in the procurement and delivery of services and materials, and the oversight of VA contracts, including fraudulent acts involving credit card misuse, contracts, and procurement by VA employees or contract agents	Evaluate referrals and initiate appropriate investigations in these areas	31	✓
2	Review computer generated records of VA purchase card transactions for suspicious acquisitions and initiate investigations as appropriate	Complete 4 reviews	Not complete due to competing demands on resources	

Office of Audit

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
1	Complete the audit to review the effectiveness and efficiency of VHA's construction contract award and administration process	Issue the report	Postponed due to competing demands	Carried over to FY 2005
2	Complete the audit of VHA's National Acquisition Center operations and contract administration	Issue the report	Report issued	✓
3	Complete the audit to assess VA's management controls over VA's Government Purchase Card Program	Issue the report	Report issued	✓
4	Complete the audit to assess VA's compliance with the National Energy Conservation Act of 1978 and Executive Order 13123	Issue the report	Postponed due to competing demands	Carried over to FY 2005

Office of Audit

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
5	Conduct preaward and postaward contract reviews to: assess the accuracy and completeness of pricing and sales data as required by Federal supply service contracts, determine price reasonableness and identify contract over-charges, and ensure compliance with statutory pricing provisions	Complete 62 preaward and postaward contract reviews	104	✓
6	Complete the audit of VHA's local procurement practices	Issue the report	Report issued	✓

GOAL: INFORMATION MANAGEMENT

Determine if VA's information systems are adequately protected and provide accurate, complete, and timely information in order to improve performance, cut costs, and enhance customer service; and investigate fraud and other computer-related crimes against VA.

Office of Investigations

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
1	Initiate investigations involving instances of fraud and mismanagement involving VA computer systems or other computer-related crimes directed at the VA	Evaluate referrals and initiate appropriate investigations in these areas	9	✓
2	Conduct Computer Crime Investigator (CCI) capability briefings for VA Information Security Officers and VA OIG investigators to ensure personnel are cognizant of the CCI program, its responsibilities, and the requirement and procedures for reporting criminal and administrative violations involving VA computer systems	Conduct 5 briefings	5	✓

Office of Audit

No.	Activity	FY 2004 Goal	FY 2004 Actual	Goal Achieved
1	Conduct the annual audit of the Department's implementation of FISMA	Issue the report	Report issued	✓
2	Conduct a special review of VA's Applications Patch Management	Issue the report	Report issued	✓

What We Plan to Accomplish in FY 2005

The performance plan for FY 2005 is guided by our latest OIG Strategic Plan for 2005-2010, which includes five strategic goals guiding the direction of all OIG audits, investigations, and health care inspections. The strategic plan focuses on examining major management challenges and high-risk areas for criminal activity, waste, abuse, and inefficiency within the Department; and it offers solutions to problems associated with those areas.

FY 2005 STRATEGIC GOALS

The OIG has identified the following 5 strategic goals that direct the investment of all OIG resources:

- Access to High Quality and Safe Health Care
- Accuracy and Timeliness of Benefits Claims Processing
- Reliability of Financial Management Systems
- Efficient and Economical Procurement Practices
- Efficient and Secure Information Technology

ACCESS TO HIGH QUALITY AND SAFE HEALTH CARE

Office of Investigations

No.	Activity	FY 2005 Goal
1	Initiate fraud investigations in the VA health care system including claims for medical benefits or unauthorized medical care, workers' compensation, and beneficiary travel	Evaluate referrals and initiate appropriate investigations in these areas
2	Initiate employee misconduct investigations in the VA health care system including instances of patient abuse, conflicts of interest, resource misuse, travel abuse, and misconduct regarding official time on the job and corresponding time keeping	Evaluate referrals and initiate appropriate investigations in these areas
3	Initiate pharmaceutical investigations involving instances of theft or diversion by both employees and non-employees	Evaluate referrals and initiate appropriate investigations in these areas

Office of Investigations

No.	Activity	FY 2005 Goal
4	Initiate joint investigative cases with the VA Police relating to crimes committed by VA employees, patients, and visitors in order to ensure the safety of VA medical facilities	Evaluate referrals and initiate appropriate investigations in these areas
5	Increase employee consciousness regarding the indicators of fraud and the procedures for referral of matters of criminal conduct to the OIG by conducting briefings for VA employees during visits to VA medical facilities	Conduct 155 briefings
6	Initiate drug diversion criminal investigations based on a comparison of verified death match data with VHA pharmacy records	Evaluate data and initiate appropriate investigations in this area

Office of Audit

No.	Activity	FY 2005 Goal
1	Complete the evaluation to assess the effectiveness of VHA's CBOC planning process and management controls	Issue the report
2	Conduct proactive CAP reviews of the management of services provided to veterans and eligible beneficiaries at VA medical facilities with emphasis on predefined pulse points	Participate in 48 health care CAP reviews
3	Analyze the pulse points emphasized during CAP reviews at VA medical facilities, provide input for consolidated summary addressing findings and recommended actions to improve health care operations, and identify and evaluate emerging issues	Issue consolidated CAP report
4	Audit VHA's report on capacity for specialized medical treatments	Issue the report
5	Attestation of VA's detailed accounting submission	Issue the report
6	Review of VA's rural development efforts	Issue the report
7	Complete evaluation of waiting list scheduling and data validity	Issue the report
8	Complete audit of physicians' time and attendance	Issue the report
9	Complete audit of VHA use of fee basis appointments	Issue the report
10	Audit of physician staffing levels	Start audit
11	Audit of pharmacy and drug accountability	Start audit

Office of Healthcare Inspections

No.	Activity	FY 2005 Goal
1	Review of internal controls and patient safety issues in VHA pharmacies	Issue the report
2	Review of MCCF/clinical documentation in VHA medical facilities	Review during 48 health care CAP reviews
3	Review of management efficiencies and patient safety issues in VHA operating rooms	Complete the review
4	Review of VHA programs for homeless veterans	Issue the report
5	Review of pressure ulcer prevention and management practices in VHA facilities	Review during 20 health care CAP reviews and issue the report
6	Review and analysis of selected VHA medical outcomes	Review during 20 health care CAP reviews
7	Review of medical record clinical documentation to support resident supervision	Issue the report
8	Review of Quality Management programs in VHA medical facilities	Review during 48 health care CAP reviews
9	Hotline inspections	Issue 15 hotline reports

ACCURACY AND TIMELINESS OF BENEFITS CLAIMS PROCESSING

Office of Investigations

No.	Activity	FY 2005 Goal
1	Initiate investigations involving instances of employee or beneficiary fraud	Evaluate referrals and initiate appropriate investigations in these areas
2	Initiate investigations involving instances of employee misconduct in the management, delivery, and processing of benefits and services including theft of government property, embezzlement of VA funds, misuse of appropriated funds, and resource misuse	Evaluate referrals and initiate appropriate investigations in these areas
3	Initiate investigations involving instances of fraud in the Loan Guaranty program	Evaluate referrals and initiate appropriate investigations in these areas
4	Increase employee consciousness regarding the indicators of fraud and the procedures for referral of matters of criminal conduct to the OIG by conducting briefings for VA employees during visits to VA regional offices	Conduct 48 briefings

Office of Investigations

No.	Activity	FY 2005 Goal
5	Complete fugitive felon data matching and sharing agreements with other law enforcement organizations	Complete 4 new agreements
6	Conduct computer matches between fugitive felon data provided by law enforcement organizations and VA record systems	Complete 12 computer matches
7	Initiate planning for a proactive international bbenefits review investigation project involving the payment of VA benefits to veterans living in foreign countries to identify cases of fraudulent receipt of VA funds	Initiate planning of the investigation project
8	Evaluate earnings and eligibility verification data and initiate appropriate criminal investigations	Evaluate data and initiate appropriate investigations
9	Conduct a computer match between data provided by Department of Defense data and VA record systems to identify fictitious veterans and other erroneous payments	Conduct the computer match
10	Issue San Juan benefit review report	Issue report

Office of Audit

No.	Activity	FY 2005 Goal
1	Complete the evaluation to determine the reasonableness of VBA rating decisions made on claims of current and former employees	Issue the report
2	Conduct proactive CAP reviews of claims processing and services provided to veterans and eligible beneficiaries at VAROs	Conduct 12 benefit CAP reviews
3	Prepare a summary report detailing systemic weaknesses, significant findings, and recommended actions needed to improve VARO operations	Issue the report
4	Initiate audit of Systemic Technical Accuracy Review (STAR) program	Start audit
5	Initiate audit to determine accuracy of benefits processing at the Pension Maintenance Centers	Start audit
6	Review of Post Traumatic Stress Disorder (PTSD) disability claims	Start audit
7	Audit of VBA benefit payments to incompetent beneficiaries	Start audit
8	Audit of VBA's VETSNET system development initiative	Start audit

RELIABILITY OF FINANCIAL MANAGEMENT SYSTEMS

Office of Investigations

No.	Activity	FY 2005 Goal
1	Initiate investigations involving instances of fraud and mismanagement occurring in VA's financial management activities and systems	Evaluate referrals and initiate appropriate financial investigations
2	Review computer generated records of VA purchase card transactions for suspicious acquisitions and initiate investigations as appropriate	Conduct a review

Office of Audit

No.	Activity	FY 2005 Goal
1	Monitor the contractor audit of VA's FY 2004 enterprise fund financial statements	Ensure proper completion of the required annual audit
2	Monitor the contractor audit of the FY 2004 CFS as required by the CFO Act of 1990 and the Government Management Reform Act of 1996	Ensure proper completion of the required annual audit
3	Complete audit of MCCF first party debts	Issue the report
4	Report on the promptness of VA's payments for water/sewer services for VA's Washington, DC facilities	Issue the report
5	Monitor the contractor audit of the FY 2004 CFS as required by the CFO Act of 1990 and the Government Management Reform Act of 1996	Complete the audit
6	Monitor the contractor audit of VA's FY 2004 enterprise fund financial statements	Complete the audit
7	Monitor single audit requirements (A-133) impacting VA	Conduct recurring reviews

EFFICIENT AND ECONOMICAL PROCUREMENT PRACTICES

Office of Investigations

No.	Activity	FY 2005 Goal
1	Initiate investigations involving instances of fraud and mismanagement in the procurement and delivery of services and materials, and the oversight of VA contracts, including fraudulent acts involving credit card misuse, contracts, and procurement by VA employees or contract agents	Evaluate referrals and initiate appropriate investigations in these areas
2	Initiate investigations involving instances of fraud in construction	Evaluate referrals and initiate appropriate investigations

Office of Audit

No.	Activity	FY 2005 Goal
1	Complete the audit to review the effectiveness and efficiency of VHA's construction contract award and administration process	Issue the report
2	Complete the review of the Department's implementation of the Zegato Travel Initiative	Issue the report
3	Complete the audit evaluating contracting services provided other Government agencies	Issue the report
4	Complete the audit to assess VA's compliance with the National Energy Conservation Act of 1978 and Executive Order 13123	Issue the report
5	Conduct preaward and postaward contract reviews to assess the accuracy and completeness of pricing and sales data as required by federal supply service contracts, determine price reasonableness, identify contract over-charges, and ensure compliance with statutory pricing provisions	Complete 64 preaward and postaward contract reviews
6	Complete the review of vocational rehabilitation service contracts	Issue the report
7	Complete the evaluation of VACO procurement activities	Issue the report
8	Complete the audit of VHA's acquisition of medical transcription services	Issue the report
9	Complete an audit of selected VACO IT contracts	Issue the report
10	Complete evaluation of alleged mismanagement of National Longitudinal Study	Issue the report
11	Evaluation of VA medical oxygen supply	Issue the report

EFFICIENT AND SECURE INFORMATION TECHNOLOGY

Office of Investigations

No.	Activity	FY 2005 Goal
1	Initiate investigations involving instances of fraud and mismanagement involving VA computer systems or other computer-related crimes directed at the VA	Evaluate referrals and initiate appropriate investigations in these areas
2	Conduct Computer Crime Investigator (CCI) capability briefings for VA Information Security Officers and VA OIG investigators to ensure personnel are cognizant of the CCI program, its responsibilities, and the requirement and procedures for reporting criminal and administrative violations involving VA computer systems	Conduct 5 briefings

Office of Audit

No.	Activity	FY 2005 Goal
1	Conduct the annual audit of the Department's implementation of FISMA FY 2004	Issue the report
2	Conduct the annual audit of the Department's implementation of FISMA FY 2005	Start audit
3	Conduct an audit of VA firewalls	Start audit
4	Conduct an audit of VA system development lifecycle program	Start audit
5	Perform penetration testing of VA systems	Start audit

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APPENDIX E

OIG OPERATIONS PHONE LIST

Investigations

Headquarters Investigations Washington, DC ..... (202) 565-7702
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Newark Resident Agency (51NJ) Newark, NJ ..... (973) 297-3338
Pittsburgh Resident Agency (51PB) Pittsburgh, PA ..... (412) 784-3888
Washington Resident Agency (51WA) Washington, DC ..... (202) 530-9191
Southeast Field Office (51SP) Bay Pines, FL ..... (727) 319-1215
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) 308-6664
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Cleveland Resident Agency (51CL) Cleveland, OH ..... (216) 552-7606
Kansas City Resident Agency (51KC) Kansas City, KS ..... (913) 551-1439
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New Orleans Resident Agency (51NO) New Orleans, LA ..... (504) 619-4340
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San Diego Resident Agency (51SD) San Diego, CA ..... (619) 400-5326
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OIG OPERATIONS PHONE LIST (CONT'D)

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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 F

GLOSSARY

CAP	Combined Assessment Program
CMOP	Consolidated Mail Out Pharmacy
CoreFLS	Core Financial and Logistics System
DAS	Data Analysis Section
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
HUD	Department of Housing and Urban Development
I&T	Office of Information and Technology
IG	Inspector General
IRS	Internal Revenue Service
IT	Information Technology
MCI	Master Case Index
NCA	National Cemetery Administration
NCIC	National Crime Information Center
NLETS	National Law Enforcement Telecommunications System
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
OMB	Office of Management and Budget
OI&T	Office of Information and Technology
PCIE	President's Council on Integrity and Efficiency
SSA	Social Security Administration
SSN	Social Security Number
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
WCP	Workers' Compensation Program

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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.

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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)

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To FAX:	**(202) 565-7936**
To Send Correspondence:	**Department of Veterans Affairs** **Inspector General Hotline (53E)** **P.O. Box 50410** **Washington, DC 20091-0410**
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E-mail Address:	**vaoighotline@mail.va.gov**

Department of Veterans Affairs
Office of Inspector General
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