Office of Inspector General

Semiannual Report to Congress

October 1, 1999 – March 31, 2000

FOREWORD

I am pleased to submit the semiannual report on the activities of the Office of Inspector General (OIG) for the period ended March 31, 2000. This semiannual report is issued in accordance with the provisions of the Inspector General Act of 1978, as amended.

OIG oversight of major Department of Veterans Affairs' (VA) programs resulted in systemic improvements and increased efficiencies in areas of medical care, benefits administration, procurement, financial management, and facilities management. OIG audits, investigations, and other reviews identified over $272 million in monetary benefits, for an OIG return on investment of $13 for every dollar expended. A particular noteworthy accomplishment was an audit of prosthetic supply inventories which identified opportunities to reduce inventories by $31 million. Additional OIG accomplishments during the period included 164 arrests, 124 indictments, 125 criminal convictions, and 301 administrative actions, foremost of which were cases involving health care and benefits fraud and employee misconduct.

VA, the second largest Department in the Federal Government, operates the largest health care system in the United States. The OIG Office of Healthcare Inspections continues to focus on quality of care issues to include a proactive review of the Veterans Health Administration's (VHA's) coordination and management of the hepatitis C virus initiative. Healthcare inspectors also conducted reviews of essential aspects of VHA clinical operations and patient treatment processes and made recommendations for improvement.

OIG has continued its Combined Assessment Program (CAP) to evaluate the quality, efficiency, and effectiveness of VA medical services. CAP combines the skills of OIG's major components to provide collaborative assessments of key operations and programs at VA medical centers on a cyclical basis. The CAP reports highlighted numerous opportunities for improvement.

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

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

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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 March 31, 2000. The following statistical data highlights OIG activities and accomplishments during the reporting period.

DOLLAR IMPACT	Dollars in Millions
Funds Put to Better Use	$260.5
Dollar Recoveries	$5.4
Fines, Penalties, Restitutions, and Civil Judgments	$6.6
RETURN ON INVESTMENT	
Dollar Impact ($272.5) / Cost of OIG Operations ($20.74)	13 : 1
OTHER IMPACT	
Arrests	164
Indictments	124
Convictions	125
Administrative Sanctions	301
ACTIVITIES	
Reports Issued	
Combined Assessment Program	4
Audits	16
Contract Reviews	16
Healthcare Inspections	6
Administrative Investigations	8
Investigative Cases	
Opened	404
Closed	229
Hotline Activities	
Contacts	7,452
Cases Opened	438
Cases Closed	256

OFFICE OF INVESTIGATIONS

During the semiannual period, the Office of Investigations, comprised of a Criminal Investigations Division and an Administrative Investigations Division, focused its resources on investigations that have the highest impact on the programs and operations of the Department. Criminal investigative priority continues to target cases of public corruption and major thefts, instances where incapacitated veterans fall victim to unscrupulous fiduciaries, and fraud involving programs for the delivery of benefits to veterans. Emphasis has been placed on safety and security at VA medical centers (VAMC) and a strong working

relationship has been developed with the VA Office of Security and Law Enforcement along with VA police throughout the nation. Immediate response to allegations of fraud is absolutely essential and demonstrates that the OIG will take decisive action against those who prey on veterans and will hold accountable those VA employees who disregard their public trust responsibilities. During the period, the Criminal Investigations Division concluded 229 investigations resulting in 249 judicial actions and over $14 million recovered or saved. The Administrative Investigations Division concentrated its resources in the investigation of allegations, generally against high-ranking VA officials, concerning misconduct and other matters of interest to the Congress and the Department. The division completed 13 administrative investigations this semiannual period and issued 8 reports. These investigations resulted in administrative action taken against 10 high-ranking officials and other employees, and 20 corrective actions taken by management to improve VA operations and activities.

Veterans Health Administration

The following are examples of investigations in which Veterans Health Administration (VHA) employees and contractors have been charged with various illegal activities. (i) A VA psychologist was sentenced after pleading guilty to scheming to defraud VA by submitting false invoices for computer equipment, ostensibly ordered for veterans who were participants in a vocational rehabilitation program. The psychologist, conspiring with the owner of a private computer company, approved false invoices for payment but never delivered the computers to veterans. The psychologist received more than $50,000 from the conspirator for taking part in the scheme. (ii) A VA nurse pleaded guilty to making false statements to obtain workers' compensation benefits and was sentenced to imprisonment, home detention, probation, and restitution. The nurse falsified Department of Labor (DOL) forms and received approximately $223,000 in workers' compensation benefits for a job-related injury while she was working as a nurse in a company she owned and operated. (iii) Four individuals who were employed by two companies that had contracted to perform a $7.8 million renovation project on a VAMC were sentenced after being found guilty to charges of contract fraud. Over 3 years they collectively received over $770,000 in Government payments to which they were not entitled. Three of them were sentenced to serve terms in a Federal penitentiary and collective restitution of more than $1.5 million. The two companies were each ordered to pay $500,000 in restitution. (iv) The director of operations of a nursing care facility that contracted with VA to supply nursing-home care to veterans was sentenced to prison after being convicted on charges of engaging in a scheme to defraud the Government, income tax fraud, and money laundering after it was found that he billed VA for patient treatment dates on which no care was provided. (v) An individual who posed as a VA fee-basis doctor was indicted on charges of defrauding health care benefit programs and criminal forfeiture after an investigation disclosed that he fraudulently obtained a state license to practice medicine and then continued practicing medicine for almost 20 years. His scheme defrauded VA, Medicare, and Medicaid benefit programs of more than $3.5 million.

Veterans Benefits Administration

The following investigations are examples of fraud relating to some of the benefits programs administrated by Veterans Benefits Administration (VBA). (i) An individual was arrested on charges of loan guaranty fraud after investigation disclosed that he located buyers for VA properties, falsely represented to them that he owned the properties, and then arranged phony sales to the buyers. When the buyers took possession of the properties, they made mortgage payments directly to the individual, who claimed he would pay the mortgages on the properties. Instead, he diverted the payments for his own use, causing the VA properties to go into foreclosure, resulting in losses to VA of approximately $700,000. (ii) An individual was indicted and charged with theft, false statements, and fraud to obtain Federal employee's compensation after investigation disclosed that he received VA compensation benefits based on unemployability due to an injury, while also collecting workers' compensation from the Postal Service

for the same injury. At the time he was claiming benefits for an inability to work, he owned and operated a vehicle restoration business. As a result, he received more than $400,000 in benefits to which he was not entitled. (iii) A fiduciary for a disabled veteran pleaded guilty to charges of misappropriation by a VA fiduciary and wire fraud after investigation disclosed that he embezzled funds from his ward, an incompetent veteran. Investigation found that the individual electronically wired more than $100,000 in funds from the veteran's account to numerous out-of-state accounts under his control. (iv) An individual pleaded guilty to charges of embezzlement in connection with his actions while acting as fiduciary for more than 100 VA and Social Security Administration (SSA) beneficiaries. Investigation disclosed that, while acting as fiduciary, he embezzled over $227,000 in funds awarded to those benefits recipients requiring his services.

National Cemetery Administration

Three employees of the National Cemetery Administration (NCA) and one outside contractor were convicted on charges including theft of Government property, receiving stolen property, and providing gratuities to Government officials. Investigation disclosed that two program assistants with NCA used VA-issued Government credit cards to purchase computers, electronics, and other items and services, which they kept or sold for profit to a third NCA employee. Information surfaced during the investigation which disclosed that a sales representative for an office products company provided cash and gratuities to the two program assistants who, in exchange, made office supply purchases from the company totaling more than $100,000. All four were sentenced to a total of more than 11½ years' probation and ordered to pay a total of more than $170,000 restitution to VA.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for $213.5 Million

Audits and evaluations were conducted which focused on determining how programs can work better, while improving service to veterans. During this reporting period, 16 performance and financial audits and evaluations and 16 contract reviews identified opportunities to save or make better use of $213.5 million in monetary benefits. The Office of Audit returned $25 for every dollar spent on performance and financial audits. Contract reviews returned $19 in monetary benefits for every dollar spent.

Veterans Health Administration

The following are examples of major health care related audits. (i) A followup audit of VHA's central food production program and Advanced Food Processing and Delivery Systems (AFPDS) showed that test facilities successfully implemented the central food production program. Facilities achieved expected improvements in food service and realized or exceeded expected staff reductions. (ii) An audit of VA's Workers' Compensation Program (WCP) found that VHA is vulnerable to abuse, fraud, and unnecessary costs associated with claims in the three high-risk areas reviewed. We concluded that VHA's management of WCP cases involving these high-risk areas needs to be strengthened to assure the appropriateness of some WCP claims.

Office of Financial Management

The audit of the Department's Consolidated Financial Statements for Fiscal Years (FY) 1999 and 1998 provides an unqualified opinion. Our Report on Internal Control discusses three material weaknesses concerning (i) VA-wide information system security controls, (ii) Housing Credit Assistance (HCA)

program accounting, and (iii) fund balance with U.S. Treasury reconciliations. The Department made significant improvement to address previously reported information system security controls and HCA program accounting issues.

Contract Review and Evaluation

During the period, we completed 16 contract reviews – 9 postaward and 7 preaward reviews. Contract reviews identified monetary benefits associated with preaward and postaward reviews of $23.8 million.

Multiple Office Action

Our audit of procurement initiatives for VA's Integrated Data Communications Utility (IDCU) telecommunications support involved both the Office of Information and Technology and the Office of Financial Management. The audit found that approximately $142 million in contract modifications were not supported with adequate documentation to explain why contract cost increases were fair and reasonable. Our audit of VAMCs and the Denver Distribution Center (DDC) found that they maintain large prosthetic supply inventories that far exceed requirements for current operating needs. We reported that prosthetic supply inventories could be reduced by more than $31 million. This audit involved both VHA and the Office of Financial Management.

OFFICE OF HEALTHCARE INSPECTIONS

Program Reviews

We conducted one health care program evaluation of the treatment of veterans who require hepatitis C virus (HCV) care in VHA medical facilities. Concurrent with the program evaluation, we were asked to inspect allegations of rationing of appropriate HCV treatment. Hepatitis refers to inflammation of the liver, and may be acute and self-limited, or it may persist for a lifetime. In the latter instance, as well as being persistent, the disease may also be active and progressive, and ultimately fatal. Finally, in cases of viral-induced hepatitis, the patient infected with the virus may be a "carrier" and therefore be potentially infectious to others. In this program evaluation, we focused on one particular type of viral hepatitis—hepatitis C. Our evaluation revealed no evidence of rationing of HCV treatment. VHA has embarked on a five-pronged strategic initiative on HCV. The initiative established two HCV education and research centers. The centers will be leaders in VA's initiative to respond to the HCV epidemic and will address five areas of concentration. These areas, which do not include facility compliance or resource allocation, are: (i) patient education, (ii) health care provider education, (iii) epidemiological assessment, (iv) treatment, and (v) research. VHA headquarters officials have issued HCV treatment guidelines and provided forums for ongoing clinical education and guidance. VHA issued a mandate that all veterans seeking care in a VHA facility are to be evaluated for HCV risk. However, we found that this mandate is not fully implemented because VAMCs are not uniformly screening all veterans who seek care and some facilities did not have any risk factor screening procedures for new patients. While we recognize that implementation of the initiative will take time, the issue of uniformity of risk evaluation or screening mechanisms needs to be addressed soon. The impact of the HCV-related workload on the VHA health care system is an increasing concern to managers in VHA facilities. Increasingly, VHA resources will become more strained, and additional dedicated resources will be required at many VHA facilities to avoid delayed access to HCV care and treatment in the future.

OFFICE OF MANAGEMENT AND ADMINISTRATION

Hotline and Data Analysis

The Hotline program provides an opportunity for employees, veterans, and other concerned citizens to report fraud, waste, abuse, and mismanagement. The identification and reporting of issues such as these are integral to the goal of improving the efficiency and effectiveness of the Federal Government. During the reporting period, the Hotline received 7,452 contacts. Of this number, staff opened 438 cases, and closed 256 cases, of which 79 contained substantiated allegations. Hotline staff generated 136 letters responding to inquiries received from members of the Senate and House of Representatives. Staff recorded 39 administrative sanctions against employees and 40 corrective actions taken by management to improve VA operations and activities. The Hotline reviews found that some employees improperly used their Government credit cards, Government-leased vehicles, and Government equipment and supplies. Reviews identified several instances of misconduct by professional staff in the care and treatment of veteran patients. A Hotline review at one VA office found that funds had been diverted to an internal budget rather being returned to VHA. Reviews concerning VBA operations identified problems with a number of compensation and pension cases that warranted corrective action by management.

The Data Analysis section provides automated data processing technical assessments and support to all elements of the OIG and other Governmental agencies needing information from VA files. During the reporting period, the staff processed 386 requests for data and information. These requests are a part of more comprehensive reviews by other OIG activities that result in solutions beneficial to the VA or lead to the identification of fraud, waste, and abuse. The Data Analysis section also responds to requests from other VA program offices and renders assistance to the investigative components of other agencies. During the reporting period, this section also provided support and assistance to all OIG CAP reviews by providing 26 statistical reports that team members used to assess the effectiveness and quality of service provided to veterans.

Followup on OIG Reports

The Operational Support Division is responsible for obtaining implementation actions on previously issued audits, inspections, and reviews with over $1.018 billion of actual or potential monetary benefits as of March 31, 2000. Of this amount $860 million is resolved, but not yet realized as VA officials have agreed to implement the recommendations, but have not yet done so. In addition, $158 million relates to unresolved reviews awaiting contract resolution by VA contracting officers. After obtaining information that showed VA officials had fully implemented corrective actions, the Division took action to close 56 internal reports and 231 recommendations with a monetary benefit of $248 million.

Status of OIG Reports Unimplemented for Over 3 Years

We have added a new section to this semiannual report on the status of unimplemented OIG report recommendations issued in FY 97 and earlier. It is found on pages 66 through 71. VA management officials are required to provide the OIG with documentation showing the completion of corrective actions taken on OIG reports. In the majority of cases, program offices provide in a timely manner the actions required to implement the reports. However, we are concerned that we have 13 OIG reports that were issued in FY 97 and earlier that remain unimplemented. VBA has six reports (one report issued in FY 96 and five in FY 97), VHA has four reports (one report issued in each of the FYs' 94, 95, 96, and 97), and the Office of Planning and Analysis, Office of Human Resources and Administration, and the Office of Financial Management each have one unimplemented report (with issue dates in FY 95, FY 97, and FY 97 respectively).

VA AND OIG MISSION, ORGANIZATION, AND RESOURCES

The Department of Veterans Affairs (VA)

Background

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

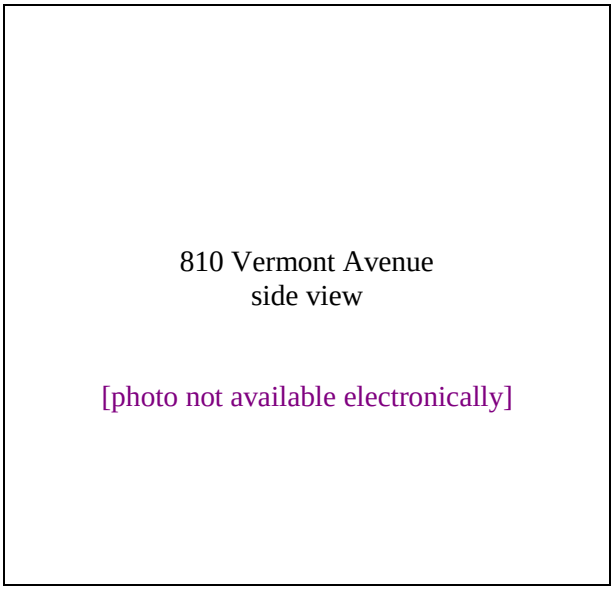
The Veterans Administration had been in existence since 1930, when Public Law 71-536 consolidated the Veterans' Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers.

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

Mission

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

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



VA Central Office as seen from Lafayette Square

Organization

VA has three administrations that serve veterans:

- Veterans Health Administration (VHA) provides health care,
- Veterans Benefits Administration (VBA) provides benefits, and
- National Cemetery Administration (NCA) provides burial and recognition.

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

- Financial Management (FIN) (Budget, Finance, Acquisition and Materiel Management (A&MM)),
- Information and Technology (I&T),
- Planning and Analysis (P&A),

- Human Resources and Administration (HRA) (Equal Opportunity, Human Resources Management, Administration, Security and Law Enforcement, and Resolution Management),
- Public and Intergovernmental Affairs, and
- Congressional Affairs.

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

Resources

While most Americans know that VA exists, few have any idea of the size of this Department, which is the Nation's second largest in terms of staffing. For FY 2000, VA estimates 204,115 employees and a $45.5 billion budget. There are an estimated 25.9 million living veterans. To serve our Nation's veterans, VA maintains facilities in every state of the union, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Philippines.

Approximately 187,000 of VA's employees work in the health care system. Health care accounts for $19.3 billion (approximately 42 percent) of VA's budget in FY 2000. VHA provides care to an average of 58,100 inpatients daily. During FY 2000, slightly more than 40 million episodes of care are estimated for outpatients. There are 172 hospitals, 766 outpatient clinics, 132 nursing home units, and 40 domiciliaries.

Veterans benefits are funded at $25.5 billion (almost 56 percent) of VA's budget in FY 2000. The 11,537 employees of VBA provide benefits to veterans and their families. Approximately 2.6 million veterans and their beneficiaries receive compensation benefits valued at $19 billion. Also, over $3 billion in pension benefits are provided to veterans and survivors. VA life insurance programs have 4.5 million policies in force with a face value of over $450 billion. Almost 280,000 home loans will be guaranteed, with a value of almost $32 billion.

The National Cemetery Administration currently operates and maintains 119 cemeteries and estimates 1,406 employees in FY 2000. Operations of NCA and all of VA's burial benefits account for approximately $300 million of VA's $45.5 billion budget. Interments in VA cemeteries continue to increase each year, with 83,300 estimated for FY 2000. Approximately 343,000 headstones and markers will be provided for veterans and their eligible dependents in VA cemeteries, state veterans' cemeteries, and private cemeteries.

VA Office of Inspector General (OIG)

Background

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

Role and Authority

The Inspector General Act of 1978 states that the IG is responsible for: (i) conducting and supervising audits and investigations; (ii) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect fraud and abuse in, the programs and operations of VA; and (iii)

keeping the Secretary and the Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action.

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

Organization

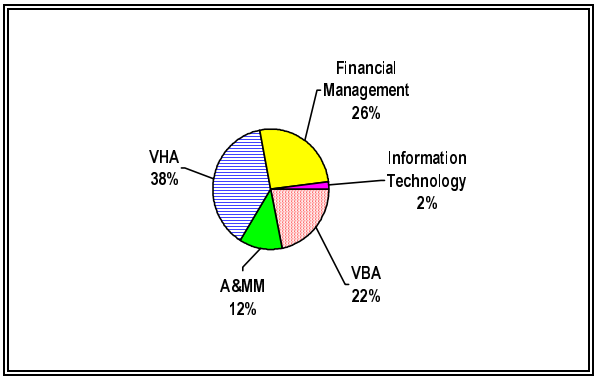
Allocated full time equivalent (FTE) for the FY 2000 staffing plan was as follows:

OFFICE	ALLOCATED FTE
Inspector General	4
Counselor	5
Investigations	102
Audit	167
Management and Administration	51
Healthcare Inspections	31
TOTAL	**360**

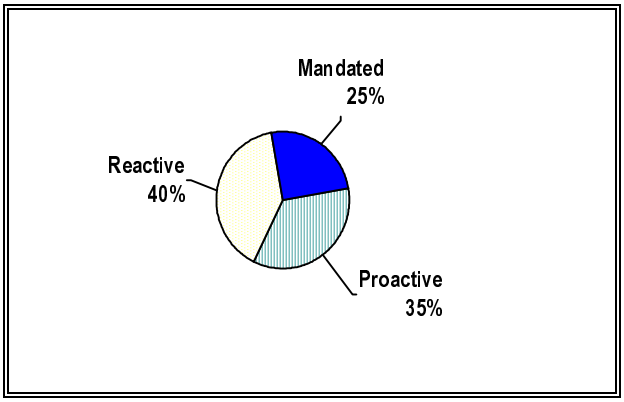
In addition, 24 FTE are reimbursed for a Department contract review function.

FY 2000 funding for OIG operations is $45.7 million, with $43.2 million from appropriations and $2.5 million through reimbursable agreements. Approximately 85 percent of the total funding is for personnel salaries and benefits, 5 percent for official travel, and the remaining 10 percent for all other operating expenses such as contractual services, rent, supplies, and equipment.

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



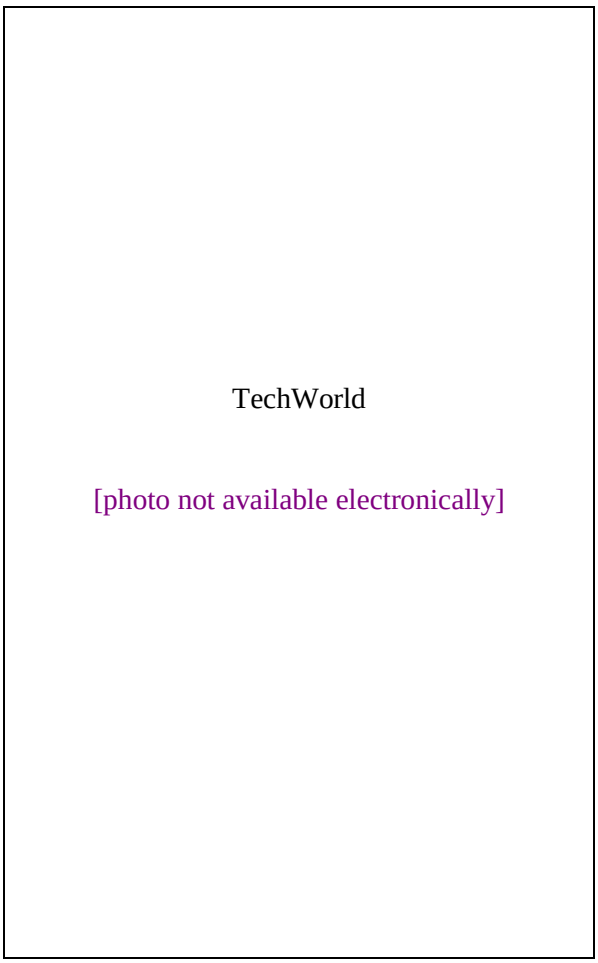
The following chart indicates percent of OIG resources which have been devoted to mandated, reactive, and proactive work.



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

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

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



TechWorld, home to VA Office of Inspector General

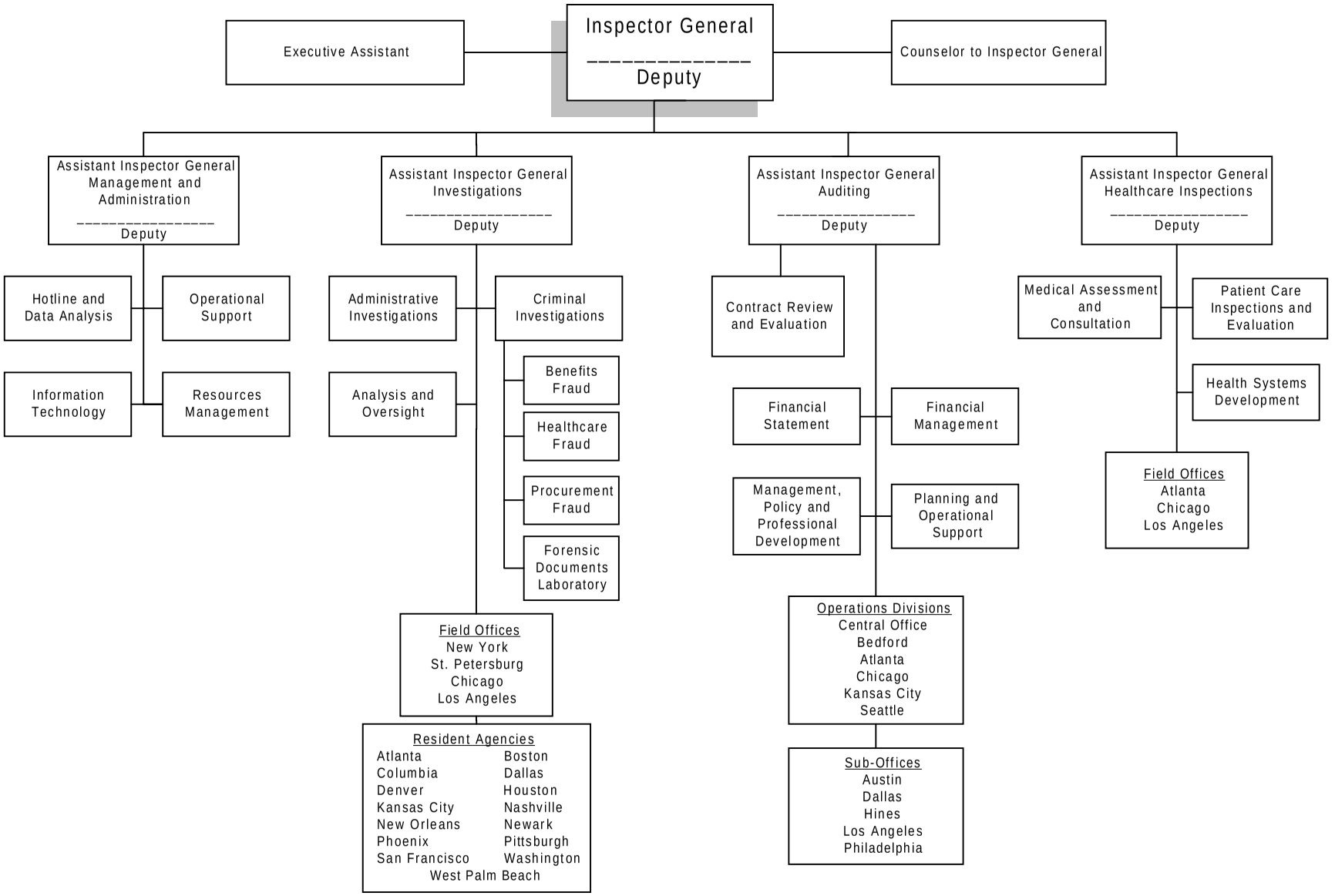
OIG Mission Statement

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

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

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

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL



COMBINED ASSESSMENT PROGRAM

Combined Assessment Program Overview

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

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

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

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

Representatives from the Office of Healthcare Inspections conduct a Quality Program Assistance (QPA) review. These are proactive reviews which incorporate the use of standardized survey instruments to evaluate the quality of care provided in VA healthcare facilities. These facilities are evaluated to determine the extent to which they are contributing to VHA's ability to accomplish its mission of providing high quality healthcare, improved patient access to care, and high patient satisfaction.

CAP team

[photo not available electronically]

A VA OIG CAP Team

The following is a summary of the four CAP reports completed this period. It includes highlights of our activities and areas that we identified as vulnerable and in need of greater management attention.

VAMC St. Louis

The OIG conducted a CAP review at VAMC St. Louis, June 7 - 11, 1999. The following is a summary of the review.

Quality Program Assistance Review - The QPA identified areas of concern that affected the quality of patient care. The report discusses

radiology service's management, quality of films, and resident physician time and attendance; nurse staffing shortages; patient privacy; employee and patient safety; waiting times; rewards and recognition practices; employee morale; and environmental concerns.

Management Control Issues - We identified a number of management control issues that needed to be strengthened. The report discussed opportunities for improvement in the facility's ambulance contract, fee-basis procedures, purchase card management, and use of Government vehicles.

Office of Investigations Fraud and Integrity Awareness Briefings - Four briefings were conducted while on-site. Investigators briefed staff on ways to recognize fraudulent situations, and discussed the procedures and details needed for sending referrals to the OIG Office of Investigations.

We made a number of observations and recommendations that warranted management attention. (*CAP Review, Department of Veterans Affairs Medical Center, St. Louis, MO, 99-00695-8, 10/28/99)*

Edward Hines, Jr. VA Hospital

The OIG conducted a CAP review at the Edward Hines, Jr. VA Hospital, July 12 - 16, 1999. The following is a summary of the review.

Quality Program Assistance Review - The QPA identified several issues that required management attention, including adjusting staffing levels of nursing service employees assigned to patient care, assessing the professional mix of primary care providers, assessing the closure of the radiology section in the ambulatory care center, reducing the waiting times for patients receiving prescriptions, and evaluating management's use of available awards to its employees.

Management Control Issues - The management control review identified opportunities to improve operations by implementing unannounced narcotics inspection procedures, improving drug destruction procedures and pharmacy security, improving surgeon productivity, increasing staff assigned to decision support system implementation, increasing controls over usage of Government purchase cards, part-time physician timekeeping procedures, and obtaining patients' agreements to pay copayments.

Fraud and Integrity Awareness Briefings - Six briefings were conducted for over 130 VA employees that discussed the recognition of fraudulent situations, referrals to the Office of Investigations, and the type of information needed in making a complaint or referral.

The review also evaluated 10 issues/allegations referred to the OIG Hotline. We made a series of observations and recommendations that we believe warrant management attention. The Medical Center Director provided acceptable comments to all recommendations. *(CAP Review, Edward Hines, Jr. VA Hospital, Hines, IL, 99-0173-18, 11/22/99)*

VAMC Philadelphia

The OIG conducted a CAP review at VAMC Philadelphia, from September 20 - 24, 1999. The following is a summary of the review.

Quality Program Assessment - This medical care review identified several issues that required management attention to ensure high quality patient care. These include timeliness of services, improving the facility environment, employee education and staffing issues, ambulatory care services, patient and employee concerns, and quality assurance.

Management Control Issues - We identified opportunities to improve management of funds,

strengthen controls over assets and expenditures, reduce costs, increase revenues, improve clinic utilization, and enhance patient care services.

Fraud and Integrity Awareness Briefings and Hotline Allegations – These briefings discussed issues concerning the recognition of fraudulent situations, referral of issues to the Office of Investigations, and the type of information needed to make a complaint referral.

We made a series of observations and recommendations that we believe warrant management attention. The Director generally agreed to address the areas of concern and provided specific plans for corrective action. *(CAP Review, VAMC Philadelphia, PA, 99-00161-24, 12/30/99)*

"I just finished reading the CAP on Philadelphia. I think it was well done and will strengthen our facilities to have this kind of feedback. I am sure that during the process it seems like a lot of work, but looking back, I think our facilities will recognize the value. I'm sure you get lots of positive feedback but just wanted to say good job."

Acting Under Secretary for Health

Carl Vinson VAMC Dublin Review

The OIG conducted a CAP review at the Carl Vinson VAMC Dublin, November 15 - 19, 1999. The following is a summary of the review.

Quality Program Assistance Review – While we found the medical center had a comprehensive quality management program in place, we identified some opportunities to further enhance its effectiveness. We also identified several issues that required increased management attention to ensure high quality patient care. These issues include: the quality and documentation of inpatient treatment goals and discharge plans; management and oversight of the domiciliary program; implementation of a structured and therapeutic post traumatic stress disorder program to effectively reduce the anxiety and address the dissatisfaction of patients; and monitoring of intermittent staffing shortfalls and filling of vacant physician and nursing positions.

Management Control Issues – Overall, the medical center maintained an effective system of financial management controls. For most controls tested, we identified only minor deficiencies. Areas reviewed which require greater management attention include reducing excess inventory costs of medical supplies, reducing the lag time for billing third-party insurers, and improving the documentation of means tests. We also concluded management needed to address employees' concerns and perceptions about the quality of patient care, the work environment, and personnel management practices in order to enhance morale.

Fraud and Integrity Awareness Briefings and Hotline Allegations – Medical center staff were briefed on recognition of fraudulent situations, referral of issues to the Office of Investigations, and the type of information needed to make a complaint referral. An administrative investigation concluded that Hotline allegations referred to the OIG were not substantiated. The results of that investigation will be addressed in a separate report.

We made a number of observations and recommendations that warranted management attention. The Medical Center Director concurred with the recommendations and provided acceptable implementation plans. *(CAP Review, Carl Vinson VAMC, Dublin, GA, 00-00358-69, 3/20/00)*

OFFICE OF INVESTIGATIONS

Mission Statement

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

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

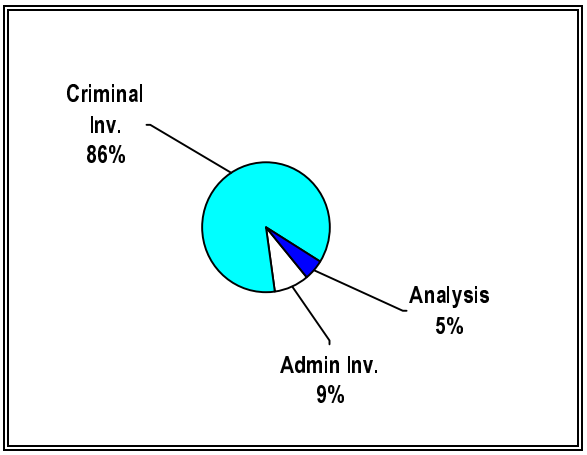
I. Criminal Investigations Division - The Division is primarily responsible for conducting investigations into allegations of criminal activities related to the programs and operations of VA. Criminal violations are referred to the Department of Justice for prosecution. The Division is also responsible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

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

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

Resources

The Office of Investigations has 102 FTE allocated to the following areas.



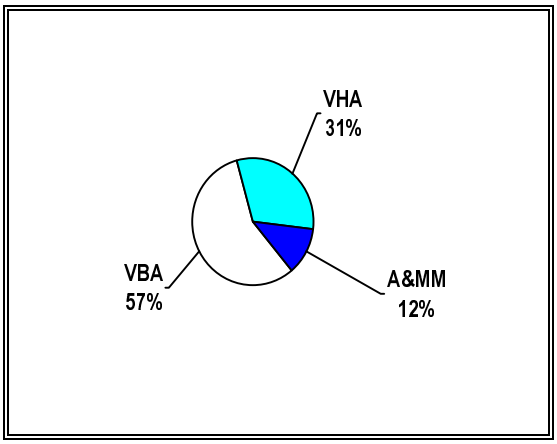
I. CRIMINAL INVESTIGATIONS DIVISION

Mission Statement

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

Resources

The Criminal Investigations Division has 84 FTE for its headquarters and 19 field locations. These individuals are deployed in the following program areas:



Overall Performance

Output

- 229 investigations were concluded during the reporting period. The performance goals for output were met.

Outcome

- Arrests - 164
- Indictments - 124
- Convictions - 125
- Monetary benefits - $14.3 million
- Administrative sanctions - 263

Cost Effectiveness

- The average cost of conducting the 229 closed investigations was $5,190. Each investigation averaged a return of $62,676, resulting in approximately $12 returned for every $1 spent.

Timeliness

- Average work days from receipt of allegation to initiation of investigation averages 39 days against a goal of 30 days.
- Average work days from initiation of investigation to referral to an assistant U.S. attorney was 186 days versus our goal of 180 days.

Customer Satisfaction

- Customer satisfaction survey forms were provided to each prosecutor upon referral of an investigation for criminal prosecution. All ratings received exceeded 4.0 and averaged 4.5 out of a possible 5.0 (5.0 means highly satisfied and 1.0 means dissatisfied).

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

Veterans Health Administration

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

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

Employee Integrity

Theft/Diversion of Pharmaceuticals

- A VAMC pharmacist pleaded guilty in state court to four counts of procurement by misrepresentation and was sentenced to four

consecutive 1-year probationary terms, and was ordered to continue a drug rehabilitation program. A joint investigation by VA OIG, the U.S. Drug Enforcement Administration (DEA), VA police, and local police disclosed the individual stole oxycodone (a generic form of Percocet) tablets, and two liquid syrup narcotic medications containing the controlled substance hydrocodone from the VA pharmacy. Investigation further disclosed that he replaced the stolen controlled substances with non-controlled substances. In a previous administrative action against the individual, he entered into a settlement agreement with the VAMC where he agreed to voluntarily take a change to a lower grade GS-5 medical clerk position, from his GS-12 pharmacist position.

- A VAMC employee was arrested by the VA OIG, Federal Bureau of Investigation (FBI), and local police on charges of theft of Government property and drug diversion. Pursuant to the arrest, search warrants were executed on the individual's home, office, and a storage shed, where property was found that was identified as belonging to the VAMC. The VA items found included computers, computer equipment, video cameras, and video cassette players. The individual, who was in charge of the disposal of excessed drugs at the VAMC, also was found to be in possession of approximately 75 separate prescription drug items (bottles of pills, blister packs, tubes, etc.), which he was not supposed to have removed from the VAMC. Many of the items still bore the original prescription label from the VAMC patients for whom they were originally intended. Approximately 1,000 videotapes were also seized, leading to allegations of possible involvement in child pornography. The investigation is continuing.

- A VAMC registered nurse was arrested on charges that she diverted narcotics from the VAMC. A joint investigation by VA OIG and VA police disclosed the nurse tampered with bottles of liquid morphine, diverting quantities of the drug for her own use, and replacing the missing quantity with water in order to hide the diversion.

- A former VAMC pharmacist was sentenced to 2 months' home detention, 3 years' probation, restitution of $1,000, and a fine of $5,000. The sentencing was the result of a joint investigation by VA OIG and a state board of pharmacy, which disclosed the individual stole more than $4,500 worth of prescription pharmaceuticals from the VAMC, then sold them at a discounted price to another individual who owned and operated a private pharmacy. The private pharmacist knew the drugs had been taken from VA, but continued to sell the stolen pharmaceuticals in his pharmacy at the standard retail markup rate. The private pharmacist previously entered a guilty plea to charges of receipt of stolen Government property and his sentencing is pending. The VA pharmacist resigned from his VA position during the course of this investigation.

- A VAMC registered nurse was suspended from employment after she admitted to the diversion of controlled pharmaceuticals for personal use. A joint investigation by VA OIG and VA police disclosed the individual altered narcotics administration forms to show she administered medications to patients who, in actuality, had been transferred off the ward or who had not been prescribed the medication.

- A VAMC registered nurse admitted during the course of a joint investigation by VA OIG, DEA, and VA police to having diverted controlled pharmaceuticals from VAMC supplies for personal use. The individual was terminated from VA employment pursuant to the investigation and agreed to enter a drug rehabilitation program.

- A VAMC certified registered nurse anesthetist admitted to the diversion of controlled pharmaceuticals for personal use. As

a result of the admission and pursuant joint VA OIG, DEA, and VA police investigation, the individual was terminated from employment at the VAMC, and his state nurse anesthetist license was placed on probationary status for a 5-year period. Judicial pursuit of this matter continues.

- A VAMC medical clerk was charged in a felony criminal complaint with obtaining a controlled substance by misrepresentation. The individual was subsequently arrested by VA OIG special agents and admitted to stealing pre-signed prescription forms that he completed and had filled at the VAMC pharmacy.

- A VAMC registered nurse was suspended from employment without pay for a period of 2 weeks; was removed from duties as charge nurse at the acute care unit in the VA and reassigned to other duties; was reduced one pay grade; and was directed to enter the VA employee assistance program. These disciplinary actions are the result of a joint investigation by VA OIG and VA police, which disclosed the individual allegedly stole drugs from the unit where he worked and falsified records to conceal his thefts.

Possession/Sale of Illegal Drugs

- A former VAMC housekeeping aide pleaded guilty to one count of possession of crack cocaine, and a former VAMC dental clerk was sentenced to 2 years' supervised probation. A joint VA OIG and FBI undercover investigation disclosed the former housekeeping aide, the former dental clerk, along with two additional individuals employed as VAMC food service workers sold cocaine and marijuana on VAMC grounds. The housekeeping aide was arrested along with one of the food service workers after selling crack-cocaine on several occasions to a VA OIG informant. The dental clerk had previously been arrested on charges of selling controlled substances to a cooperating witness.

- A VAMC motor vehicle operator was arrested on charges of loitering and possession with intent to distribute a controlled substance. A joint investigation by the VA OIG, U.S. Housing and Urban Development (HUD) OIG, and local police disclosed the individual used a Government vehicle and traveled off VA property to a public housing development where he allegedly purchased illicit drugs.

- An individual surrendered to authorities and was placed under arrest pursuant to an outstanding arrest warrant. A joint investigation by special agents of the VA OIG and the Food and Drug Administration (FDA), and local police, disclosed the individual had been involved in a conspiracy to purchase pharmaceutical drugs that were either stolen or diverted from VA pharmacies. The elaborate scheme targeted drugs which could be obtained far below wholesale market price from unlicensed pharmaceutical brokers involved in reintroducing diverted and stolen drugs into the market through independently owned pharmacies. Investigation showed that drugs issued to beneficiaries of Government sponsored healthcare programs were also targeted by the brokers and owners of the pharmacies involved in the scheme. The investigation continues.

- A VAMC compensated work therapy employee was arrested on charges of theft of Government property and distribution of illicit drugs on VA property. During the course of a joint investigation by the VA OIG, DEA, and VA police, the individual sold to an undercover VA agent 11 computers and 5 laser-jet printers that he had stolen from the VAMC. In addition, the individual sold the undercover agent more than 100 grams of crack-cocaine. Subsequent searches of the individual's home and vehicle disclosed additional computers and computer related equipment belonging to the VAMC.

Theft and Embezzlement

- A former VA agent cashier was sentenced to 5 months' imprisonment, 5 months' home confinement, 3 years' supervised release, and was ordered to pay $47,816 restitution to the Government. The sentencing was the result of a VA OIG investigation which disclosed the individual, over a period of 4 years, stole more than $40,000 in cash co-payments made by veteran patients, converting the funds to her personal use instead of depositing the funds into a VA account as required.

- A VAMC registered nurse was charged in a multi-count criminal complaint with elderly/ dependant abuse and grand theft. The charges were the result of a VA OIG investigation, which disclosed the individual solicited money from VA spinal cord injury patients and kept it for her own use. It is alleged the nurse received more than $3,000 from patients.

- A former VAMC housekeeper was indicted on charges of theft of Government property. A joint investigation by VA OIG and VA police disclosed the individual had stolen computers and environmental maintenance equipment from the VA facility. Investigation further determined the individual was involved in a series of thefts amounting to a VA loss of over $53,000.

- A former police officer at a VA medical and regional office center pleaded guilty to one count of making false statements after having been arrested and indicted on charges of theft of Government property. A joint investigation by VA OIG, Defense Criminal Investigative Service (DCIS), and VA police disclosed the individual stole VA equipment and supplies, including a police radio. The former officer also falsely claimed that his girlfriend was his wife on official personnel documents in order for her to fraudulently obtain Government health insurance benefits. The individual resigned from his position while under investigation.

This is some of the Government property recovered during the execution of a search warrant by VA OIG special agents as part of an investigation of thefts of building supplies and materials from a VA Medical Center. The investigation continues.

daltile photo

[photo not available electronically]

- A former VA counseling psychologist was sentenced to 4 months' home confinement, 3 years' probation, and $67,000 restitution. The sentence was in response to his earlier guilty plea to charges he concocted a scheme to defraud VA by submitting phony invoices for computer equipment, ostensibly ordered for veterans who were participants in a vocational rehabilitation program. A joint investigation by VA OIG and the FBI disclosed the psychologist, working in conspiracy with the owner of a private computer company, approved the false invoices for payment, but never delivered the computers to the veterans. Investigation showed no computers were delivered and the

psychologist received more than $50,000 from the conspirator for taking part in the scheme. Losses to the Government were in excess of $67,000.

Acceptance of Bribes, Gratuities, Conflicts of Interest

- A former VAMC decedent affairs clerk pleaded guilty to one count of receiving compensation relating to a contract in which the Government had a substantial interest. The individual, in the course of his duties, was responsible for awarding contracts to funeral homes for the burials of deceased veterans who had no immediate family and had become wards of VA. During the course of a joint investigation by VA OIG, Internal Revenue Service (IRS) Criminal Investigations Division, and the Department of Labor (DOL), the individual admitted having accepted money from the owner of a local funeral home in return for awarding the funeral home VA business. The individual admitted in court to having accepted $40 to $50 for each referral to this funeral home during a 2-year period.

- A former VAMC director of respiratory care was sentenced to 5 months in prison, and 7 months' home confinement. The sentencing was the result of an investigation by VA OIG and VA police which disclosed the individual received gratuities from companies that conducted business with VA and filed false travel vouchers, resulting in his wrongfully receiving more than $12,000. The individual had previously pleaded guilty to one count of soliciting and receiving illegal gratuities after admitting to having received from a VA vendor a desktop computer and a laser printer for personal use in exchange for the VA's purchase of equipment from that vendor. The individual resigned from the VAMC.

- A former VAMC chief of staff pleaded guilty to a criminal information charging him with one count of conflict of interest. The plea agreement was the result of a joint investigation by the VA OIG and FBI, which disclosed the individual approved a contract for services between the VAMC and an affiliated university medical center, where he was also employed as a physician. A sentencing date is pending.

- A VAMC director of facilities management was reprimanded for creating the appearance of a conflict of interest while employed as the chief of engineering service. A joint investigation by the VA OIG, FBI, and Small Business Administration disclosed the individual hired two SBA 8a contractors to perform work on his house while they were under contract to perform VAMC work. Investigation further disclosed the construction company had been awarded millions of dollars in contracts over a period of 15 years, many of them at a VAMC. It was found the construction company defrauded Federal agencies on construction contracts. It was also revealed the company submitted false bid information in order to obtain VAMC contracts without competitive bidding under the auspices of the small business program. Subsequent to these findings, the president and vice president of the construction company were each sentenced to 6 months' home detention, 3 years' probation, 200 hours' community service, $315,000 in restitution, and a $10,000 fine.

Workers' Compensation Benefits Fraud

- A former VAMC nurse pleaded guilty to a one count criminal information charging her with making a false statement to obtain Federal workers' compensation, and was subsequently sentenced to 5 months' imprisonment, 5 months' home detention with electronic monitoring, 3 years' probation, and $10,000 restitution. A joint VA OIG and DOL OIG investigation disclosed the nurse indicated on DOL forms that she owned a share of a home health care

business as an investment, but asserted that she only had a limited role in the business and was physically unable to do any work for which she would be paid. During this time, she received approximately $223,000 in workers' compensation benefits for a job-related injury. Investigation showed, however, the nurse actually was performing services for which she was being paid, including providing services as a nurse.

- A former VA medical and regional office center licensed practical nurse, and her husband, were both charged with one count of making false statements to obtain workers' compensation benefits and aiding and abetting. A joint VA OIG and DOL investigation disclosed that, while receiving workers' compensation benefits for an on-the-job injury, the former nurse failed to disclose her involvement in her husband's siding and windows business.

Credit Card Fraud

- An individual was sentenced in local court to 364 days' incarceration and 5 years' probation after a VA OIG investigation disclosed the individual and an accomplice used Government credit cards stolen from a VAMC to purchase almost $10,000 in merchandise. The two individuals previously had pleaded guilty to using stolen credit cards. The accomplice was previously placed in a pre-trial diversion program. The two individuals advised during the course of the investigation that a former VA employee provided them with the stolen Government credit cards. The former employee removed the credit cards from a safe, gave them to the two individuals, and then intercepted the credit card invoices to conceal their fraudulent use. The former employee was fired from her position under separate circumstances, and charges are pending for her role in the thefts.

- A criminal information was filed, charging a VAMC environmental management service employee with theft of Government property. During the course of his regular duties, the individual was tasked with using a Government-issued credit card to purchase supplies for the VAMC. Investigation disclosed, however, he engaged in a scheme where he would return items he had purchased to various vendors, directing them to send refund checks directly to his home rather than to his VAMC office. Six refund checks were sent to the individual's home by vendors and the total theft amounted to more than $2,000.

- A criminal indictment was filed in state court, charging a VAMC medical administration service clerk with larceny, theft of a Government credit card, and unauthorized use of a credit card. During the course of his assigned VA duties, the individual was authorized to use a Government vehicle and to use a Government credit card to purchase gas and services related to the use of that vehicle. A joint VA OIG and VA police investigation disclosed, however, the individual misused the Government credit card, making unauthorized purchases totaling more than $8,000.

- A former VAMC supervisory respiratory therapist pleaded guilty to a criminal information charging him with theft of Government funds. The guilty plea was the result of a joint VA OIG and VA police investigation which disclosed that, over an 8-month period, the individual used a Government credit card to purchase more than $4,900 worth of items for personal use. The individual resigned from VA after receiving a notice of proposed removal.

Patient Abuse

- A VA registered nurse was arrested for abusing a patient. A criminal information was filed charging the individual with one count of

abusive sexual contact after a VA OIG investigation disclosed the nurse assaulted a number of VAMC patients in his care over a course of more than 3 years.

- A former VAMC dialysis unit nurse pleaded guilty in a state court to charges of abuse/neglect of the elderly. The plea was the result of charges filed against the nurse during the course of a joint investigation by VA OIG and local police. Investigation disclosed the former nurse, in the course of connecting a disabled veteran to a dialysis machine, left the patient unattended for a period of time while she attended to personal business. When she returned to the veteran patient, she discovered the dialysis machine had not been properly connected and the veteran patient had lost a great quantity of blood. She made attempts to conceal the blood loss and delayed calling medical personnel in to aid the veteran patient. When medical personnel did arrive to render aid, she failed to inform them of what had occurred. The former employee's plea agreement stipulates she receive 10 years probation and agree to surrender her nursing license.

- A former VAMC doctor entered a "no contest" plea in court to three counts of battery. A joint VA OIG and VA police investigation disclosed that, while employed by VA, the doctor fondled multiple patients in his care, under the premise of conducting medical exams. The doctor was sentenced to 3 year' probation, ordered to undergo counseling, and was prohibited from practicing medicine during probation.

Other Employee Misconduct

- A VAMC employee has made a monetary settlement agreement with VA for $100,000 and has agreed not to file any malpractice suits against VA. These agreements are the result of a VA OIG investigation, which disclosed the individual was wrongfully claiming 100 percent service connected disability and had filed suit against VA for $2.3 million in damages due to an incident where he had blood drawn by a VAMC nurse and claimed it caused him to sustain nerve damage. After sustaining the alleged injury, the individual claimed he could not function mentally, was unable to watch television or leave his home during daylight hours due to the psychological effects associated with his trauma. He also had threatened to file a separate suit against VA for malpractice due to the alleged injuries. Investigation disclosed that alleged disabilities were unfounded as the individual was able to operate a vehicle, pump gasoline, carry items with his injured arm, use his injured arm to open doors, and watch television. Due to the investigative efforts put forth in the case, the Government was spared the expense of defending the $2.3 million lawsuit and the potential malpractice suit as threatened by the individual.

- A former VAMC program assistant was arraigned after being indicted on charges of making false statements on a loan application to a federally insured financial institution and fraud in connection with misuse of a Social Security number. A VA OIG investigation disclosed the individual used her position at the VAMC to access personal employee information. After locating an employee with the same name, she proceeded to use that employee's Social Security number and date of birth to make a false statement on a loan application submitted to a federally insured financial institution in an attempt to purchase an automobile, cellular telephone, and other consumer items.

- A VAMC environmental management service employee was arrested and subsequently indicted by a grand jury on charges of conducting a fraudulent scheme. A joint investigation by VA OIG and VA police disclosed the individual was involved in a scheme where he stole patient identifying information, which he provided to an employee

of a wireless telephone company. The telephone company employee used the patient information to create new wireless phone accounts in patient's names and then had the VA employee sell the wireless phones. Some of the wireless telephones were sold to VAMC employees.

- A former VAMC medical instruments technician was sentenced to 100 hours' community service and 2 years' probation after being charged with making false statements. A VA OIG investigation disclosed the individual, who was responsible for maintaining dialysis equipment and water quality testing at the VAMC, falsified at least 15 water quality test reports for the dialysis unit which were submitted to the Joint Commission on Accreditation of Healthcare Organizations. When the falsified results were discovered, the VAMC was placed in a preliminary non-accredited status with the Commission.

- A former VAMC research service administrative officer was sentenced to 48 months' probation and ordered to pay $6,499 in restitution to VA. The individual previously had pleaded guilty to charges of theft of Government funds after a VA OIG investigation disclosed he submitted false information on travel vouchers while on a temporary assignment. Investigation found he submitted travel vouchers to claim reimbursement for temporary quarters, but continued to occupy the quarters after the temporary period and made them his permanent residence. Had the VAMC been aware he intended to reside permanently in the same quarters he claimed as temporary, they would not have paid his claims. The individual resigned from VA subsequent to the investigation.

- A VAMC staff physician was discharged from employment for failing to properly administer and document narcotic medication prescriptions provided to a female patient under his care, with whom he was having a relationship. From 1991 through 1997, as the primary care provider for the patient, the physician prescribed opiates to relieve pain, failing to properly document the prescriptions. Judicial action is pending.

- A VAMC nursing assistant retired from her position after being arrested and indicted on charges of submitting false statements in order to qualify for HUD subsidized housing. A joint VA OIG and HUD OIG investigation disclosed the nursing assistant underreported her VA salary to HUD, and forged the signature of the VAMC chief of human resources on documents to HUD certifying this false income, in order to receive federally subsidized housing. The false statements submitted allowed her to avoid about $10,000 in fair-market rent payments.

- A former VAMC occupational therapist was sentenced to 21 months' imprisonment, 36 months' supervised release, and $4,800 in restitution. A non-VA employee, also involved in the case, was sentenced to 18 months' imprisonment, 36 months' supervised probation, and $4,800 in restitution. The sentencings were the result of a joint investigation by VA OIG, U.S. Postal Inspection Service, and U.S. Secret Service (USSS) which disclosed the former VA employee and the other individual misused Government-owned computers and telephones in furtherance of an Internet scam. Investigation disclosed the two individuals accepted money for items they sold on the Internet, but did not provide the product to the buyers. It was found the individuals received approximately $40,000 from this illicit scam. These individuals previously pleaded guilty to one count of conspiracy to commit mail fraud and wire fraud.

- A former VA compensated work therapy program employee was sentenced to 57 months' imprisonment for the reproduction and possession of child pornography on Federal property. He previously had been arrested by VA OIG special agents after a bench warrant

was issued for failure to appear for his scheduled sentencing on the charges relating to the reproduction and possession of child pornography on Government property. A joint VA OIG and VA police investigation disclosed the individual accessed shared public computers in the VAMC library and used them to reproduce and store approximately 16 images of child pornography.

Theft of Other Property

- An individual was arrested and subsequently indicted after a criminal complaint was filed charging her with one count of negotiating a stolen Government check. A joint investigation by VA OIG and USSS disclosed the individual and a co-conspirator stole and negotiated a U.S. Treasury check totaling more than $100,000. Investigation further determined the individual and co-conspirator may have been involved in a large-scale credit card fraud scheme. The investigation continues.

- An individual was arrested and charged with trespassing and removal of Government property without authorization. A joint investigation by VA OIG and VA police disclosed the individual, an employee of a contractor doing work at the VAMC, stole electronic audio dubbing equipment belonging to the Government. The individual used the equipment to trade for illegal drugs. During the course of the investigation, the property was recovered.

- An individual was arrested on charges of burglary and criminal conspiracy after being identified as the accomplice of an individual who had previously been arrested on charges of theft from a VA outpatient center. During the course of a joint investigation by VA OIG, VA police, and local police, the individual who was previously arrested, and is currently awaiting trial, disclosed he had broken into the outpatient center and had stolen computers. He later admitted he had an accomplice during the commission of the acts, which led to this second arrest.

- A VAMC clothing room clerk was arrested and charged with theft after a VA OIG investigation into a series of thefts of patient property at the VAMC. At the time of his arrest, he was leaving the VAMC and was found to be in possession of currency and other property that had been in his care in the clothing room. He also was found to be carrying a bag of new clothing, which he admitted having stolen from items donated by veterans' service organizations for indigent patients at the VAMC. Judicial actions are pending.

Credit Card Theft

A former credit collection clerk at a major medical supply firm that did business with VA was arrested, and subsequently pleaded guilty to a one count criminal information charging him with unauthorized use of a Government credit card. A VA OIG investigation disclosed the individual had access to sensitive credit card information pertaining to Government accounts, corporate accounts and private accounts due to his duties and responsibilities at the company. The individual used his access to the sensitive information to compromise a Government credit card account number and made unauthorized transactions with the card, including the purchase of a computer that was delivered to an out of state address before it was forwarded to the individual's residence.

Assault and Threats to VA Employees

- A criminal information was filed charging a former VAMC radiology employee with making death threats to various VA employees with whom she had previously worked. A joint VA OIG and FBI investigation disclosed the individual, who had been terminated from VA

employment for assaults on fellow employees, called the VAMC and left several threatening voice mail messages indicating she wanted to kill her supervisor and other VA employees.

- An individual was found guilty of assaulting a doctor at a VAMC and was ordered to undergo a psychological evaluation. He previously had been arrested by VA OIG special agents after investigation disclosed he had become violent while seeking treatment in the VAMC emergency room and assaulted his treating physician. Two VA physicians who witnessed the incident testified in court as to the violence of his actions. The individual also threatened one of the doctors testifying in court during a break in the proceedings. Sentencing is pending.

Armed Robbery

An individual, previously employed by a credit union located at a VAMC, was tried and sentenced to 108 months' confinement, 3 years' supervised release, and restitution of $2,788 for her role in a robbery of the credit union. The credit union, a tenant at the VAMC, was robbed at gunpoint of $140,000. A joint VA OIG, FBI, and local police investigation identified the former credit union employee as being involved after evidence recovered at the scene, and testimony given by an accomplice, implicated her. The accomplice, not employed by the credit union, previously had pleaded guilty and was sentenced for his role in the case.

Construction Related Fraud

- As the result of a VA OIG investigation, a construction company that had contracted with VA to perform work on VAMCs has agreed to settle claims filed against them by their subcontractors, for failure to pay prevailing wage rates on VA construction jobs. As a result of the settlement, more than $190,000 will be released to nine subcontractors who performed work on renovations at a VAMC. The Department of the Army, who also was defrauded by the construction company, and the General Accounting Office have both debarred the construction company and its former president for an indefinite period of time. These agencies have also proposed debarment for a number of individual laborers and mechanics employed by the construction company and the nine subcontractors, due to labor standards violations.

- The final of four individuals was sentenced to 6 months home confinement, 5 years supervised release, and ordered to pay $500,000 restitution after having been found guilty on charges of contract fraud. The sentencing was the result of a joint investigation by VA OIG, DOL OIG, and FBI which disclosed the four individuals, who were employed by two companies that had contracted to perform a $7.8 million VAMC renovation project, falsified payroll and wage statements. Investigation showed the four individuals would certify on the weekly payroll reports that their employees were being paid the Federal prevailing wage. Actually, these employees were being paid substantially less. The defendants would then retain the difference for themselves. Over approximately 3 years the defendants collectively received over $770,000 in Government payments to which they were not entitled. Two individuals in the case, who were principals of one of the contracting companies, were each sentenced to 12 months and 1 day in a Federal penitentiary, 3 years' supervised release, and each was ordered to pay $500,000 restitution. The fourth individual, president of one of the companies, was sentenced to 14 months in a Federal penitentiary, 3 years' supervised release, and restitution of $500,000. The two companies were each ordered to pay $500,000 in restitution.

Procurement Fraud

- A medical products company agreed to pay the Government $101 million in criminal fines and $385 million in civil fines and penalties for fraud involving the filing of fraudulent claims for laboratory and blood testing services. A joint investigation by VA OIG, Health and Human Services (HHS) OIG, DCIS, and FBI disclosed a scheme that involved offering and paying kickbacks to private clinics if they referred laboratory and blood testing services of dialysis patients to a wholly owned subsidiary of the medical products company. The services were paid primarily by Medicare; however, VA paid the laboratory directly over $1 million for laboratory analysis services performed at VA medical facilities. It is alleged the laboratory charged VA for services not performed and for instances of unnecessary testing. Five former officials of the company either have been indicted or have pleaded guilty to charges relating to the scheme. The monetary recovery for both civil and criminal actions relating to VA's portion of the settlement agreement is $216,670.

- Four individuals were sentenced for taking part in a conspiracy to import misbranded surgical instruments, some of which were later sold to Government agencies, including VA. The four individuals conspired to represent that the instruments were of European origin and falsely labeled the instruments as such, when in actuality, the surgical instruments were manufactured in Pakistan and smuggled into the United States. The Pakistani instruments were shipped through several European countries in order to avoid detection by U.S. Customs and the FDA. European manufactured instruments are generally regarded as a better quality instrument and, therefore, command a higher price. The first of the four individuals was sentenced to 1 year and 1 day incarceration and 2 years' supervised release. The second was sentenced to 8 months' incarceration and 2 years' supervised release. The third individual was sentenced to 2 years' probation, 6 months' home confinement, 300 hours of community service, and was ordered to pay a $5,000 fine. The final individual was sentenced to 2 years' probation, 200 hours of community service, and was ordered to pay a $10,000 fine.

Contract Fraud

- The former director of operations of a nursing care facility that contracted with VA to supply nursing-home care to veterans was sentenced to 140 months' imprisonment and 3 years' supervised release. The individual's spouse, the former director of maintenance and housekeeping at the facility, was sentenced to 57 months' imprisonment and 3 years' supervised release. The two individuals also have to pay back joint taxes of more than $140,000 and the costs of the prosecution. The two were previously convicted at trial of engaging in schemes to defraud Medicaid, income tax fraud, and money laundering. A VA OIG investigation disclosed the two contracted with VA to provide patient care at their nursing facilities for patients from VAMCs. When billings to VA were compared with actual dates that patients stayed at the facilities, it was disclosed the contractors charged VA for dates on which no care was provided.

- The owner and president of a company that contracted to provide medical products and services to VA was arrested on charges that he made false statements to the Government by certifying that medical products were made in the United States when in fact they were of foreign origin. A joint investigation by VA OIG, DCIS, Army Criminal Investigative Division, and FBI disclosed the individual directed employees to remove the labels from products made in non-approved countries and repack the products in plain boxes to avoid detection by U.S. officials.

Forgery

- An individual was arrested and charged with 1 count of fraud and 35 counts of forgery. A VA OIG investigation disclosed the individual, a veteran enrolled in a VA work-study program, forged the initials of her supervisor in order to falsify time records and receive more than $2,000 in payments to which she was not entitled. The individual pleaded guilty to the charges and was accepted into a pre-prosecution probation program, where she will serve 12 months' probation and has agreed to make full restitution to VA.

- A criminal complaint was filed charging an individual participating in the VA work-study program with 12 counts each of fraud and forgery. A VA OIG investigation disclosed that, over the course of 8 months, the individual filed fraudulent time sheets claiming she performed approximately 50 hours of work-study that she did not perform. It is further alleged the individual forged the initials of her supervisor on each time sheet.

Fee Basis Fraud

- An individual employed as a registered nurse participating in the fee basis program associated with a VAMC pleaded guilty to two counts of submitting false claims to the Government. The guilty plea was the result of a joint investigation by VA OIG and the U.S. Postal Inspection Service, which disclosed the nurse fraudulently submitted false invoices for nursing visits that she did not perform. Sentencing is pending.

- An individual who had posed as a VA fee-basis doctor was indicted on six counts of defrauding health care benefit programs, and one count of criminal forfeiture. A joint investigation by VA OIG, FBI, and DCIS disclosed that in 1981 the individual allegedly fraudulently obtained a state license to practice medicine and then continued practicing medicine for almost 20 years. The individual's scheme defrauded VA health care benefit programs, Medicare and Medicaid programs, and state medical aid programs of more than $3.5 million. A trial date is pending.

Travel Benefits Fraud

- An individual who was an outpatient at a VAMC was indicted in state court after being arrested on an outstanding state arrest warrant charging him with grand theft. A joint investigation by VA OIG and VA police disclosed the individual was receiving travel benefits to which he was not entitled. The individual claimed he was living at an address approximately 130 miles from the VAMC in order to claim travel benefits from that location, when in fact he actually lived only 20 miles from the hospital and was not entitled to the travel benefits. Total loss to VA was more than $2,000 through the submission of more than 100 fraudulent travel vouchers.

- An individual was charged in state court with a felony charge of grand theft after having been arrested during the course of a joint investigation by VA OIG and VA police, which disclosed he submitted multiple false travel claims to VA. Investigation showed the individual claimed travel benefits for a commute in excess of 280 miles roundtrip, when in reality his commute was a much shorter distance.

Medical Benefits Fraud

- An individual was indicted and charged with six counts of receiving unauthorized medical care. The individual, a dishonorably discharged veteran, wrongfully assumed the identity of an eligible veteran in order to receive more than $39,000 in medical treatments at VA facilities in eight different states. Additionally, the

individual accrued numerous felony warrants and outstanding financial obligations in the name of the innocent veteran, causing the Government to seize the veteran's 1998 IRS tax refund. An arrest warrant has been issued for the individual.

- An individual was indicted on two counts of making false statements to VA in order to obtain medical benefits and two counts of using a false Social Security number. A criminal complaint previously was filed against the individual after a VA OIG investigation disclosed he provided false information to a VAMC in order to obtain a VA patient identification card, which he used to fraudulently receive VA health benefits, medical treatment, and medication to which he was not entitled. Loss to VA in medical benefits provided him was more than $1,700.

- An individual was ordered to serve 20 days' confinement and pay $1,374 restitution to VA after a VA OIG investigation disclosed he had assumed a deceased veteran's identity in order to receive VA medical services to which he was not entitled.

- An individual was indicted by a Federal grand jury and charged with theft of Government services and false statements. The charges were the result of a VA OIG investigation which disclosed the individual wrongfully used the identity of his brother, a veteran, to fraudulently obtain medical care from several VAMCs. As a result, the individual received more than $120,000 in medical care to which he was not entitled.

Veterans Benefits Administration

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

Loan Guaranty Program Fraud

Employee Misconduct

A former VA loan guaranty representative was sentenced to 4 months' home confinement, 36 months' supervised probation, and restitution in the amount of $3,670. The individual previously had pleaded guilty to one count of embezzlement after a VA OIG investigation disclosed he embezzled funds he had obtained from veterans while performing his official duties. The individual was assigned to a program designed to help veterans who were having trouble making payments on VA-guaranteed home loans. Veterans who sought the individual's assistance concerning defaulted mortgages would be advised to send him money, which he allegedly would apply to their loans. The individual then wrongfully converted the money he received from veterans to his own use.

The total amount of the embezzlement was more than $4,000.

Loan Origination Fraud

- A joint investigation by VA OIG, U.S. Postal Inspection Service, and HUD OIG resulted in the arrest of four individuals on charges they engaged in a loan origination fraud scheme for properties with loans being guaranteed by VA and HUD. An attorney and a real estate agent were both arrested after investigation disclosed they submitted documents to the Government which contained false information regarding applicant's income, assets, and liabilities. Also arrested was an individual formerly employed by a new home developer after investigation disclosed the individual allegedly produced fraudulent IRS W-2 forms and other employment verification documents for the potential home buyers. The fourth person arrested thus far was a real estate appraiser, arrested after it was disclosed the individual allegedly appraised properties above market value. With the appraised value of the home inflated, the mortgage bank was able to issue a loan for greater than the actual value enabling the buyer to pay off debt with the difference. The investigation continues.

- An individual was sentenced to 6 months' confinement in a rehabilitation center, 5 years' probation, and restitution of $25,618. He previously had pleaded guilty to submitting false statements to a lending institution after a Federal grand jury returned a seven-count indictment against him. A VA OIG investigation disclosed the individual submitted false statements to a lending institution in order to obtain a VA-guaranteed loan and then defaulted on the mortgage loan within 12 months of origination, triggering an audit of his loan processing documents. Investigation of those documents determined the individual's loan application contained inflated income information and false supporting documentation, which served as the basis for his loan approval. The subsequent default and foreclosure resulted in a loss to VA of $33,100.

Equity Skimming

- An individual was found guilty at trial on charges of making false statements and bankruptcy fraud. This individual functioned as principal officer, agent, partner, and employee of numerous entities involved in an equity-skimming scheme to acquire VA properties. A joint investigation by VA OIG and FBI disclosed the individual acquired these properties, which he then rented out to others, while failing to make property mortgage payments. Foreclosure efforts were made on the questioned properties, but those efforts were stalled by bankruptcy proceedings. Sentencing is pending.

- An individual pleaded guilty to one count of theft of Government property, and was sentenced to 1 year supervised probation and ordered to pay fines and restitution totaling $2,010. The individual previously had been indicted on charges of equity skimming after a joint VA OIG and FBI investigation determined he engaged in a conspiracy to fraudulently obtain the titles to properties whose mortgages were guaranteed by VA, but which were in default due to non-payment. The individual and the other conspirators convinced the property owners to pay them rent on the properties, with the promise that the collected rent monies would go toward the payment of their debts and their mortgages would be saved. Investigation disclosed, however, no money from the rent was ever used to pay the mortgages, with all of the money being kept by the conspirators for personal use. Judicial actions are pending.

Property Management Fraud

An individual was sentenced to 3 years' probation, 6 months' home detention, 100 hours'

of community service, and fined $1,000 after he pleaded guilty to making false statements to both VA and HUD. A joint VA OIG and HUD investigation revealed the individual misrepresented himself to VA and HUD as a real estate broker in order to participate in brokering the sale of repossessed homes. He was paid commissions, to which he was not entitled, on the sales he brokered.

Other Loan Guaranty Fraud

An individual who was the subject of an investigation on charges of loan guaranty fraud was arrested by special agents of the VA OIG and FBI, and members of a state fugitive task force. A joint VA OIG and FBI investigation disclosed the individual would locate buyers for VA properties, falsely represent to them that he owned the properties, and then arrange phony sales to these buyers. Once the buyers took possession of the properties, they would make mortgage payments directly to the individual, who claimed he would pay the mortgages on the properties. In reality, he diverted the payments for his own use, causing numerous VA properties involved in the scheme to go into foreclosure, resulting in estimated monetary losses to VA of approximately $700,000.

Beneficiary Fraud

Dependency and Indemnity Compensation (DIC) Benefits Fraud

- Two individuals were arrested for their roles in the theft, forgery, and uttering of a stolen U.S. Treasury check. A joint investigation by VA OIG, state police, and USSS disclosed the two individuals conspired to steal a VA beneficiary's DIC benefits check. One of the individuals admitted forging the payee endorsement on the check and negotiating the check at a local bank. She stated she split the proceeds of the check with the co-conspirator. The two individuals were charged with forgery, uttering a forged check, theft, theft by deception, and criminal conspiracy. A preliminary hearing has been scheduled.

- Three individuals were arrested in a joint effort by VA OIG, USSS, and local police, after a Federal grand jury returned a 41-count indictment against the three, charging each with mail fraud, conspiracy, aiding and abetting, and passing forged U.S. Treasury checks. The joint investigation disclosed that, after a VA beneficiary in receipt of DIC benefits died, her primary care givers failed to notify VA of the death and continued for more than 18 months to forge and negotiate her VA benefits checks. Loss to the Government was more than $16,000.

- An individual was indicted and subsequently pleaded guilty to theft of Government funds. A joint investigation by VA OIG and the USSS disclosed the individual diverted VA benefits that were being deposited into the checking account of his deceased wife. The wife had been in receipt of VA DIC benefits as the surviving spouse of a deceased veteran, but she failed to notify VA of her remarriage in 1983, which would have terminated the benefits. The husband, in turn, did not notify VA when his wife died in 1988. Benefits disbursed to the wife's account after her death totaled more than $80,000.

- An individual pleaded guilty to theft of public money after being charged in a criminal information with the theft of more than $38,000 in VA DIC benefits. A VA OIG investigation disclosed the individual, the son of a VA beneficiary, failed to disclose his mother's death to VA and continued for more than 15 years to allow VA DIC benefits to be direct-deposited into a bank account he shared with his mother prior to her death. Loss to VA exceeded $100,000. Sentencing is pending.

- The son of a deceased VA beneficiary signed a pre-trial diversion agreement admitting his role in the theft of VA DIC benefits. A VA OIG investigation disclosed the individual failed to disclose his mother's death to VA in 1989 and continued to forge her signature on checks to access VA DIC benefits that were deposited into her bank account. The Government also filed a civil judgement against the individual. The terms of the pre-trial diversion agreement require full restitution. The loss to the Government is more than $36,000.

- An individual was sentenced to 12 months' imprisonment, 12 months' supervised release, and ordered to pay restitution to VA of $33,703 after she admitted filing false claims with VA in order to wrongfully collect VA DIC benefits. A VA OIG investigation disclosed the individual falsified documents indicating she was married to a veteran in order to collect VA benefits.

- An individual was sentenced to 3 years' supervised probation, 2 weeks' imprisonment, 1 month home confinement, and 100 hours of community service. She previously had pleaded guilty to making false statements to the Government. A VA OIG investigation disclosed the individual had been receiving DIC benefits as the surviving spouse of a deceased veteran. Entitlement to DIC benefits terminates when the beneficiary remarries or death occurs. Investigation determined the individual failed to report her remarriage to VA and continued to collect benefits to which she was not entitled. Loss to VA totaled more than $130,000.

- An individual who wrongfully diverted her deceased mother's DIC benefits surrendered to VA OIG special agents after a warrant was issued for her arrest. The individual previously had been indicted by a grand jury on 10 counts of mail fraud and 6 counts of forgery after a VA OIG investigation disclosed that, for more than 2½ years, she failed to report her mother's death to VA, and continued to receive and negotiate benefits checks totaling more than $7,800. Judicial actions are pending.

- An individual was sentenced to 13 months' incarceration, 36 months' probation, and ordered to make VA restitution of $45,043. The sentencing was the result of a joint VA OIG and Social Security Administration (SSA) investigation which determined the individual failed to notify VA and SSA of his mother's death and, for more than 7 years, continued to receive and negotiate SSA benefits and VA DIC benefits checks intended for his deceased mother. Loss to the Government was estimated at more than $49,700.

- An individual pleaded guilty to one count of theft of Government property. A VA OIG investigation disclosed the individual failed to disclose the death of his mother, a VA beneficiary, and continued for more than 3 years to divert VA DIC benefits payable to his mother. The benefits were deposited into a joint bank account via direct deposit and were subsequently withdrawn by the individual for personal expenses. Loss to the Government was more than $33,000. Sentencing is pending.

- An individual pleaded guilty to one count of theft of Government funds after a joint VA OIG and U.S. Postal Inspection Service investigation disclosed she diverted and negotiated VA benefit checks intended for her deceased mother, the widow of a veteran. Investigation disclosed the individual failed to report her mother's death in 1997 and continued for almost 2 years to divert the benefits checks as they were sent to her mother's address. While incarcerated on another charge, she would have her husband and brother-in-law cash the checks. The husband and brother-in-law were also charged and arrested for taking part in the scheme.

- An individual was sentenced to 6 months' home confinement, 60 months' probation, and ordered to pay VA restitution of $62,400 after

pleading guilty to a criminal indictment charging her with theft of Government funds. A VA OIG investigation found the individual failed to disclose the death of her mother, a VA beneficiary, and continued to allow VA DIC benefits checks to be electronically deposited into a jointly held account. She then used the monies for her own needs, resulting in a loss to VA of $62,400.

- An individual was charged with five counts of theft of Government funds. A VA OIG investigation disclosed the individual, the daughter of a VA beneficiary, failed to disclose her mother's death to VA and continued to allow VA DIC benefits checks to be direct-deposited into a bank account she shared with her mother prior to her death. Loss to VA was over $28,000.

- The son of a VA beneficiary was indicted on two counts of theft of Government funds after a joint investigation by VA OIG and SSA OIG disclosed that he stole more than $23,000 in VA DIC benefits and $12,900 in Social Security funds. Investigation determined the individual failed to disclose his mother's death and continued to allow DIC benefits funds and SSA funds to be electronically deposited into a joint bank account, which he then withdrew for his own use. When questioned about the diversion of the funds, the individual admitted to the misuse of the funds.

- An individual was sentenced to 6 months' home confinement, 5 years' supervised probation, and restitution of $94,600. The sentencing was the result of a joint investigation by VA OIG, FBI, and local police, which disclosed the individual failed to notify VA of her mother's death, and continued to divert VA DIC benefits that were electronically deposited into her deceased mother's bank account. She had previously pleaded guilty to an indictment charging her with theft of VA benefits.

- An individual who was the nephew of a VA beneficiary was arrested after a VA OIG investigation disclosed he diverted VA benefits payments. Investigation revealed the individual failed to notify VA of the death of his aunt, a beneficiary in receipt of VA DIC benefits payments, which would have caused the payment of benefits to cease. After her death, the individual forged his aunt's signature to endorse her checks and converted the money to his own use. He also forged her signature and provided false information on a VA marital status questionnaire and on a replacement check request. For more than 6 years he carried on this fraud, causing the Government a loss of more than $65,000.

- An individual was arrested based on a criminal complaint filed charging him with theft of Government funds. The individual previously was indicted by a grand jury after a VA OIG investigation determined that, over of period of 8 years, he fraudulently diverted more than $118,000 in VA benefits to which he was not entitled. Investigation disclosed the individual failed to notify VA of the death of his mother, a VA beneficiary in receipt of DIC benefits. Upon her death, the DIC benefits were intended to remain for the care of the individual's stepsister, who was designated as a helpless child of the VA beneficiary. Instead, the individual accessed the bank account where the benefits monies continued to be electronically deposited, and diverted the monies for his own use. During the course of the investigation, the individual confessed to the theft. A trial date is pending.

- An individual was arrested pursuant to a criminal indictment charging her with embezzlement and theft of public money. The indictment and subsequent arrest were the result of a VA OIG investigation, which disclosed the individual failed to notify VA of the death of her grandmother, a widow in receipt of VA DIC benefits. Investigation disclosed the individual continued to receive the benefits in her

grandmother's name, and converted to her own use more than $44,000 in VA benefits.

Pension Benefits Fraud

- An individual pleaded guilty to one count of submitting a false certificate in order to commit fraud. A VA OIG investigation disclosed the individual falsified her application for VA widow's pension benefits by failing to report her earnings. Investigation also disclosed the individual had been divorced from the veteran for almost 2 years prior to her submitting the application for benefits, which would have rendered her ineligible to receive benefits. Sentencing is pending.

- An individual pleaded guilty to an indictment charging him with theft of Government money. The conviction was the result of a VA OIG investigation, which determined the individual, a veteran in receipt of VA pension benefits, failed to report family income earned which would have rendered him ineligible for the VA benefits. Loss to the Government was more than $30,000.

- An individual who was in receipt of VA pension benefits was indicted by a Federal grand jury on four counts of making false statements to the Government. The indictment charged that, for more than 5 years, the individual operated a full-time residential maid service, the income from which exceeded the amount allowed by law for an individual to be eligible to receive pension benefits. She perpetrated the scheme by falsifying annual reports to VA declaring that she had no outside employment income. Loss to the Government exceeded $27,500.

- An individual pleaded guilty to a one count criminal information charging him with theft of Government funds. A VA OIG investigation disclosed the individual, a veteran in receipt of VA pension benefits, failed to report employment income to VA, which would have altered the amount of benefits he would have received. As a result of this action, he received benefits in excess of $24,000 to which he was not entitled. Sentencing is pending.

- An individual was arrested on charges of making false statements to VA. A joint investigation by VA OIG, U.S. Postal Inspection Service, and FBI disclosed the individual, who was in receipt of VA widow's pension benefits, made false statements and misrepresented her employment status in order to receive benefits monies to which she was not entitled. Investigation showed that, from 1996 through 1999, the individual stated she did not work when, in fact, she was employed the entire time. The false statements allowed her to collect more than $20,000 in widow's pension benefits to which she was not entitled.

- An individual was indicted by a Federal grand jury and charged with theft of Government property and making forged endorsements on U.S. Treasury checks. A VA OIG investigation disclosed the individual, the sister of a deceased veteran, failed to notify VA of her brother's death, and continued for more than 3 years to forge and negotiate his VA pension benefits checks. Loss to the Government as a result of this scheme was over $30,000.

- An individual was indicted on charges of wire fraud and misuse of a Social Security number. The indictment was the result of an investigation conducted by a benefits fraud task force comprised of Federal investigators from VA OIG, SSA OIG, and the U.S. Postal Inspection Service. The task force was formed to investigate identity thefts and fraud schemes related to claims for benefits involving Government benefits programs. Investigation disclosed the individual, a veteran, applied for and received a false Social Security account number and attempted to obtain benefits under that number. The individual was already

receiving veteran's benefits, to which he was entitled, under his true identity.

Compensation Benefits Fraud

- An individual was indicted by a Federal grand jury, charged with two counts of theft, one count of false statements, and one count of fraud to obtain Federal employee's compensation. A joint VA OIG and U.S. Postal Inspection Service investigation disclosed the individual was receiving VA compensation benefits based on unemployability due to an injury, and was also collecting workers' compensation for the same injury from the Postal Service. In addition to wrongfully collecting benefits from two agencies, investigation further disclosed that, during the period he was claiming benefits for an inability to work, he owned and operated a vehicle restoration business. As a result, this individual received more than $400,000 in benefits to which he was not entitled.

- An individual was charged with one count each of forgery, receipt of stolen property, and larceny. A joint investigation by VA OIG and local police disclosed the individual had stolen from a veteran two VA compensation checks, totaling more than $2,700. After stealing the checks she forged the veteran's signature, deposited the checks in her own bank account and used the funds for personal use. She subsequently pleaded guilty to the charges and agreed to make restitution.

- An individual entered into an agreement in U.S. District Court wherein she admitted guilt in unlawfully diverting funds for her own use which were originally intended for her sister, a VA and SSA beneficiary. A joint VA OIG and SSA OIG investigation disclosed she diverted funds totaling more the $15,700 from VA and more than $14,200 from SSA. Pursuant to the agreement, the court imposed 18 months of probation, 50 hours of community service, and ordered the individual to make restitution to the Government agencies in the amounts stolen.

- A veteran was sentenced to 5 years' probation, 4 months' home detention, and was ordered to pay restitution of $45,500 after pleading guilty to conspiracy to defraud and conspiracy to steal and convert VA and SSA funds. A joint VA OIG and SSA investigation revealed that, from November 1987 to December 1996, the veteran and his wife submitted false statements to VA and SSA regarding their income and marital status in order to receive both VA and SSA payments. The veteran's wife reported to SSA that she was single during that time, with no other income other than her SSA benefit payments, in order to continue receiving the benefits which would have terminated with remarriage. Further, after the couple divorced in 1996, the veteran failed to report the fact of the divorce to VA, which would have caused a reduction in VA benefits. As a result of these unlawful actions, the Government paid the couple more than $45,500 in benefit payments to which they were not entitled.

- A VA regional office (VARO) senior claims examiner was indicted and subsequently pleaded guilty to charges of theft of Government property, making and using a document containing false and fraudulent statements, and endeavoring to obstruct and impede a Federal investigation. A VA OIG investigation disclosed the individual created records which fraudulently inflated the disability rating for a co-worker at the VARO, enabling the co-worker to wrongfully obtain more than $40,000 in compensation benefits. He allegedly attempted to thwart the ensuing investigation by destroying documentary evidence, concocting a false story to provide to VA investigators, and counseling the co-worker to provide false information to investigators. The co-worker involved in the case previously pleaded guilty to similar charges and has been sentenced.

- An individual was indicted and subsequently arrested on charges of mail fraud and aiding and abetting, as a result of a joint investigation by DOL, IRS Criminal Investigations Division, and VA OIG. Investigation disclosed the individual provided false statements to the Government when he applied for VA and DOL benefits based on 100-percent disability. During the period of time he was receiving benefits, he worked on numerous construction projects, but reported to VA that he was not working. Through this scheme, he received $61,664 in VA benefits for which he was not entitled. He also received DOL unemployment compensation benefits during this time. In addition, subsequent to his indictment on conspiracy and false claim charges relative to an IRS investigation, he lied to the U.S. District Court on a financial affidavit filed for the purpose of obtaining court appointed legal representation.

- An individual was sentenced to 5 months' imprisonment, 3 years' supervised release, and ordered to make restitution of more than $67,000 to VA. The individual, a veteran, was previously convicted of making false statements on VA employment questionnaires indicating he had not been employed due to a service-connected disability. A VA OIG investigation disclosed the individual had earnings during the time he alleged an inability to work. In addition, because of his alleged unemployable status due to his disability, his children received educational benefits to which they would not otherwise have been entitled. The false statements resulted in an estimated total loss to VA of more than $90,000.

- An individual was arrested after a VA OIG investigation determined he fraudulently collected VA compensation benefits under two different claim numbers. Based on submission of an altered military discharge document and a VA benefits application containing false information, the individual received more than $21,000 in VA benefits over a 4 year period despite the fact that he had not yet been discharged from military service. Additionally, while continuing to receive monthly payments under the first wrongful claim, for 2 years he also received more than $10,000 based on a second false claim. As a result, the individual received over $32,000 to which he was not entitled. Judicial actions are pending.

- Two individuals who operated a personal care home were indicted and subsequently pleaded guilty to charges of theft of public money, false statements, and aiding and abetting. A joint investigation by VA OIG, FBI, and SSA OIG disclosed the two individuals stole VA survivor benefits checks intended for a veteran's widow who had previously resided in their personal care home. The thefts began after the widow moved out of the home, when the individuals failed to notify VA of the widow's change of address, and continued after the widow had died. Total loss to VA was more than $20,000. The investigation further disclosed that fraudulent billings for medical services were submitted to VA by the individuals. The fraud amounted to a $23,200 loss to VA. Sentencing is pending.

- The former spouse of a veteran pleaded guilty to charges of mail fraud after a VA OIG investigation disclosed that, for more than 25 years, she submitted fraudulent documents to VA in order to receive VA disability benefits to which she was not entitled. A VA OIG investigation showed the individual filed documents fraudulently reflecting that the veteran resided at certain addresses and requested that his benefit checks be mailed to those addresses when, in fact, only the former spouse resided at those addresses, not the veteran to whom the benefits were rightly owed. The former spouse proceeded to open a bank account in both names, forged the veteran's endorsement on the benefit checks and wrongfully converted the monies to her own use. During the time the fraud was taking place, the veteran was unaware that he was owed disability

benefits and that his ex-wife was fraudulently receiving them instead of him. Loss to the Government was approximately $21,000.

- An individual was indicted by a Federal grand jury on one count of theft of Government funds and one count of making false statements after being arrested by VA OIG special agents. While on trial on unrelated state charges, the individual testified he had defrauded VA by falsifying his marital status in order to collect extra dependent benefits. He stated in court that he had made claims to VA that he was married from 1983 to 1999, when he actually had divorced his wife in 1982. Investigation confirmed he had in fact misled VA in order to receive the extra benefits. On multiple occasions throughout the 16-year period, he falsely certified he was married and continued to list his former wife as a dependent. Loss to the Government was $5,900.

Fiduciary Fraud

- An individual who served as a VA-appointed fiduciary for his brother-in-law, a veteran judged incompetent to manage his own accounts, was arrested and charged with theft by conversion. A joint investigation by VA OIG and local police disclosed that, while serving as fiduciary for the veteran, the individual was responsible for receiving and disbursing VA funds to pay the veteran's expenses. All funds not immediately used for expenses were to be maintained in an interest-bearing account for future use by the veteran. Investigation disclosed the individual did not deposit any of the veteran's money into such an account, but rather used the veteran's money for personal expenses.

- A woman appointed as fiduciary for her father, an incompetent veteran, was arrested by VA OIG and local sheriffs on state charges of exploitation of the elderly. A joint investigation disclosed the individual received the funds intended for her father while he was in a nursing home facility, using the funds for herself. During this time, she failed to use the funds to pay for her father's nursing care.

- An individual was indicted by a grand jury and found guilty on six counts of theft of Government funds. A VA OIG investigation disclosed that from approximately January to August 1998, the individual, acting in her capacity as fiduciary for a disabled veteran, diverted in excess of $8,100 of the veteran's VA benefit funds for her own personal use. Sentencing is pending.

- An individual was indicted by a grand jury on four counts of making false statements to the Government. A joint VA OIG and SSA OIG investigation disclosed the individual, who was designated as fiduciary for her veteran husband after he was judged unable to manage his benefits, made false statements to VA and SSA pertaining to the existence of dependent children, in order to increase the amount of benefits. Investigation determined that one of the claimed dependent children failed to meet dependency requirements and that the other did not exist. Loss to the Government was $35,000.

- A fiduciary for a disabled veteran pleaded guilty after being charged in an indictment with one count of misappropriation by a VA fiduciary and eight counts of wire fraud. A VA OIG investigation disclosed he embezzled funds from his ward, an incompetent veteran. The indictment charged that, over the course of approximately 3 years, the individual electronically wired more than $100,000 in funds from the veteran's account to numerous out-of-state accounts under his control. The individual had executed a fiduciary agreement with VA, in which he agreed to serve as custodian-in-fact for the veteran. Pursuant to this agreement, he was required to use all money paid by VA strictly for the benefit of the veteran. Instead, however, the individual ordered

interstate wire transfers of funds from the fiduciary account to several of his personal accounts.

- An individual was indicted by a grand jury and charged with one count each of making a false statement and mail fraud. A VA OIG investigation disclosed the individual, who formerly acted as fiduciary for her brother, an incompetent veteran, submitted a false statement to VA regarding income she received on behalf of the veteran. Investigation showed she failed to provide an accounting of the veteran's funds after it was discovered that no monthly maintenance payments were being made to the veteran's care facility.

- A two count criminal information was filed against an individual operating as a VA-appointed fiduciary, and he subsequently pleaded guilty to misappropriation by a fiduciary and fraudulent conversion of Social Security benefits. A joint VA OIG and SSA OIG investigation disclosed the individual misappropriated money from the bank accounts of six veterans for whom he was appointed fiduciary. Investigation disclosed he stole the money in order to pay off personal debts. Judicial actions are pending.

- An individual pleaded guilty to a criminal information charging him with embezzlement in connection with his actions while acting as fiduciary for VA and SSA beneficiaries. A joint investigation by VA OIG and SSA OIG disclosed that, while acting as fiduciary for more than 100 VA and SSA beneficiaries, the individual embezzled over $227,000 in funds awarded to those benefits recipients requiring his services. Sentencing is pending.

Credit Card Fraud

A VARO claims clerk pleaded guilty to charges of forgery and credit card theft, and was sentenced to 3 years' supervised release and is barred from ever again seeking employment with the Federal Government. She had resigned from her position after being arrested and indicted on the charges. A joint investigation by VA OIG and local police disclosed the individual stole a VA identification card belonging to a fellow employee, and proceeded to use the stolen card to impersonate the other employee, applying for credit cards in that person's name. At the time of her arrest the individual had prepared a fictitious credit card application for a retail establishment and was in the process of purchasing hundreds of dollars worth of merchandise from the store.

Board of Veterans Appeals

Employee Misconduct

An individual employed as the chief of an administrative team with the Board of Veterans Appeals (BVA) pleaded guilty after being arrested on charges of attempted tampering with physical evidence and was placed in a pretrial diversion program after admitting responsibility for his offenses. As part of the plea, he will perform 60 hours of community service at a VAMC and has resigned from VA. A joint investigation by VA OIG and the FBI disclosed the individual, in the course of his regular duties, was responsible for processing approximately 200 veteran's appeals a week. A percentage of the appeals submitted for processing were labeled as being extremely time sensitive, in that they were claims made by veterans in need of immediate assistance because they were terminally ill or because their home may have been on the verge of foreclosure. Investigation disclosed the individual knowingly allowed a large amount of unprocessed materials to accumulate in and around his office and he falsified weekly reports in order to conceal the

existence of these unprocessed materials. During an office reorganization, more than 1,300 unprocessed items were found accumulated in the individual's office area. While most of the material found was between 1 and 2 years old, there were some items which dated as far back as 1994. Among the unprocessed materials found were more than 500 items containing evidence related to veterans' appeals including some of the aforementioned urgent, time sensitive items, as well as Congressional materials. The large amount of unprocessed mail had a substantial and continuing effect on BVA operations, and significant corrective action is required to resolve the administrative aspects of the case.

Office of Human Resources and Administration

Support to VA Central Office

Theft and Embezzlement

An individual working as a night engineer for a VA contractor was arrested and charged with one count of theft. In the course of a VA OIG investigation into theft of VA property, the individual admitted he had stolen computer related items from VA.

Employee Misconduct

A VA management analyst was sentenced to 1 month probation and agreed to make full restitution, after having pleaded guilty to a criminal information that charged him with theft of state unemployment benefits. While pursuing unrelated allegations against the individual, a joint investigation by VA OIG and the FBI developed evidence that the individual forged a co-conspirator's signature to a series of unemployment benefits checks and related work certifications. The individual then disbursed part of the stolen benefits monies to the co-conspirator, an inmate in a Federal prison facility, and used the remaining money for support of the inmate's family.

National Cemetery Administration

Employee Integrity

A total of four individuals, three employed with NCA and one outside contractor, have all been convicted on charges including theft of Government property, receiving stolen property, and providing gratuities to Government officials. A joint VA OIG and FBI investigation disclosed two of the VA employees, both NCA program assistants, used VA-issued Government credit cards to make purchases of computers and electronic equipment, and other items and service, which they either kept for themselves or sold for profit to the third NCA employee. During the course of the investigation, information surfaced which disclosed the outside contractor, a sales representative for an office products company, provided cash and gratuities to the two program assistants who, in exchange, made office supply purchases from the company totaling more than $100,000. All four have been sentenced. One of the program assistants was sentenced to 3 years' probation and ordered to pay $1,393 in restitution to VA. The second program assistant was sentenced to 6 months' home detention with electronic monitoring, 4½ years' probation, and $170,000 in restitution to VA. The NCA employee who purchased the stolen merchandise was sentenced to 1-year probation after pleading guilty to the charges. The sales representative for the office supply company was sentenced to 3 years' probation, restitution of $2,000 to VA, and 200 hours'

community service after pleading guilty to providing gratuities to a Government official.

Washington Post
Metro Section
Article

[photo not available electronically]

OIG Forensic Document Laboratory

The OIG operates a nationwide forensic laboratory service for fraud detection, which can be used by all elements of VA. The types of requests routinely submitted to the laboratory include handwriting analysis, typewriting, inks, paper, photocopied documents, and suspected alteration of official documents. During this reporting period, the forensic laboratory conducted examinations which provided valuable evidence of fraud and forgery. Some examples of these cases are: (i) examinations uncovered that an individual had forged VA documents to obtain veterans' life insurance and an application to obtain a VA loan; (ii) examinations identified the subject of an OIG investigation as the author of 13 different signatures on stolen U.S. Treasury checks; (iii) examinations discovered that the widow of a veteran submitted false documents to VA to continue to receive her deceased husband's benefits to which she was not entitled.

A breakdown of laboratory examinations conducted during the period follows.

Laboratory Cases for the Period	
Requester	Cases Completed
OIG Office of Investigations	4
VA Regional Offices	15
Office of Security and Law Enforcement	1
Other Federal Agency	1
TOTAL	**21**

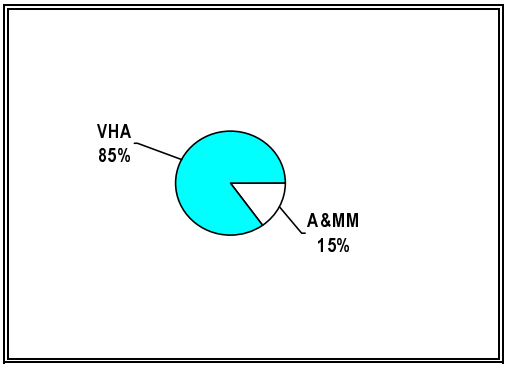
II. ADMINISTRATIVE INVESTIGATIONS DIVISION

Mission Statement

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

Resources

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



Overall Performance

During the reporting period the Division closed 13 cases, 4 of which had Congressional interest.

Output

- During the reporting period, 8 reports were issued. Five cases resulted in administrative closures.

Outcome

- VA managers agreed to take administrative actions against 10 high-ranking officials, including one who had retired after our draft report was issued. They also agreed to take 20 corrective actions to improve operations and activities as a result of these investigations, to include issuing bills of collection in 10 instances for collection of monies due VA.

The administrative investigation reports discussed below address serious issues of misconduct against high-ranking officials and other high profile matters of interest to the Congress, Secretary, VA managers, media, and the general public.

Veterans Health Administration

Use of Government Resources, Conduct, and Travel Issues

An administrative investigation substantiated that a Veterans Integrated Service Network (VISN) Director misused a Government vehicle to regularly commute from his residence to work. His actions constituted an unauthorized use of Government property, from which he personally and improperly benefited. We also substantiated the Director's Chief Financial Officer disregarded the laws and regulations pertaining to the use of Government vehicles, thereby allowing the Director to misuse the vehicle. VHA officials agreed with our recommendations to take appropriate administrative action against the Director and the Chief Financial Officer, and to ensure the Director repays the General Services Administration's mileage charges applicable to the unauthorized miles driven. We also substantiated the Director used his position for his own private gain by having his staff construct an above standard sunporch on his on-

station quarters, at Government expense. We substantiated the Director wasted Government funds by unnecessarily exchanging a Government vehicle leased by his former duty station with a Government vehicle leased by the VISN office. On another matter, we found the Director improperly used his personal credit card to pay for official travel expenses, thereby accruing frequent flyer mileage points that were available for his personal use. We also found the Director improperly used his Government position to obtain Government airline tickets, or segments of Government airline tickets, when there was no official necessity for him to travel. VHA officials agreed to take appropriate administrative action against the Director for the above improprieties, and to issue bills of collection to him to recover money due the Government. *(Use of Government Resources, Conduct, and Travel Issues, Connecticut Health Care System and Central Plains VISN, 99-01783-43, 2/29/00)*

Frequent Flyer and Other Travel Issues

An administrative investigation substantiated that a VA Medical Center Director improperly converted over 142,000 frequent flyer mileage points earned through official travel for his personal use. Further, the Director did not redeem any frequent flyer mileage points he earned from official travel to offset the cost of subsequent official travel, as required. We also substantiated the Director engaged in other travel irregularities, including not always using contract air carriers, not using the approved travel management agent, and using a personal credit card to pay for official expenses, including some of his airfare, while on Government travel. VHA officials agreed with our recommendations to take appropriate administrative action against the Director; and bill him for the value of personal trips he took using points earned on official travel, and for the excess cost of trips he made that were not at the prevailing contract rate. They also agreed with our recommendation to direct him to use, in a timely manner and for official Government purposes only, the points he had accumulated based on official travel. As a final issue, we concluded the Director failed to fully cooperate with us during this investigation because he declined to provide his testimony under oath and would not allow the two interviews we conducted with him to be tape-recorded, as required by VA policy. The Chief Network Officer agreed to address this issue with the Director and all network and facility executives. *(Use of Frequent Flyer Mileage Points and Other Travel Issues, VAMC Long Beach, CA, 99-01781-32, 2/25/00)*

Conduct Issue

We conducted an administrative investigation into an allegation that a VISN Director improperly participated in the selection of her spouse to perform collateral duties as a VISN advisor. Although we found the Director did participate in the selection of her spouse, we identified no law or regulation she violated. However, we concluded the Director did not heed the advice in a VHA Information Letter. In that Letter, the former Under Secretary for Health cautioned VHA staff to carefully consider that having an intimate personal relationship with a subordinate places at risk the confidence of other subordinates and limits the leader's effectiveness. We noted the Director's action undermined her leadership ability. We made no formal recommendation on this matter, but suggested the Director and her spouse be advised, in specific terms, of what the nature and extent of their on-the-job relationship should be, and that this relationship be monitored to ensure it does not adversely affect morale within the VISN. *(Misconduct and Other Issues, VA Heartland Network, Kansas City, MO, 99-01779-21, 12/9/99)*

Personnel Practices

An administrative investigation substantiated that a VA Health Care System Director and Associate Director for Operations inappropriately proceeded to hire an individual, who had once worked for the Director in another location, into a position the Merit Systems Protection Board ordered belonged to the former incumbent. The Director and Associate Director for Operations subsequently displayed poor position management by non-competitively placing the newly hired individual in another, upgraded position. Although the individual was qualified and eligible for both positions, deficiencies in the hiring and placement process created an appearance of preferential treatment. VHA officials agreed to our recommendation to take appropriate administrative action against the Director and Associate Director, and to amend the local merit system promotion plan. *(Personnel Practices, Central Texas Veterans Health Care System, 99-01789-28, 1/25/00)*

Use of Government Resources

An administrative investigation substantiated that a VISN Director inappropriately approved the use of official resources for an employee to attend a function sponsored by the VA – National Medical Music Group. We also substantiated that, while a medical center director, the Director wasted resources by allowing officials to prepare excessively costly media presentations to recognize retiring employees. VHA officials concurred with our recommendation to take appropriate administrative action against the Director for these improprieties. *(Use of Government Resources and Other Issues, Great Lakes Healthcare System, Hines, IL, 97-00957-29, 1/19/00)*

Veterans Benefits Administration

Conduct, Attendance, and Travel

An administrative investigation substantiated that a VARO Director knowingly and intentionally misused his position to make personal telephone calls at Government expense. He violated VA travel policy by claiming personal calls as officially necessary. Further, he used his Government-issued cellular telephone and calling card to make personal calls. When the Director became aware a complaint might be made against him, he repaid most of these charges. The Director also violated duty and leave regulations by being absent on 14 occasions without charging annual leave, charging 32 hours of sick leave for unauthorized purposes, and inappropriately requesting that 250 hours of annual leave be restored in 1997 and 1998. The requests were approved, although the requirements of VA policy were not met. Finally, we substantiated improprieties relating to the Director's use of Government resources for personal business, including his use of Government equipment, travel and purchase cards, and frequent flyer mileage points. The Director retired from Federal service while our report was in draft. However, VBA officials told us they would have taken appropriate administrative action against the Director, as we recommended, had he not retired. VBA officials agreed to issue the Director bills of collection for the remaining unpaid telephone charges, the debt associated with his absences without charge to annual leave, and his inappropriate restoration of leave, for a total of over $20,000. VBA officials also took appropriate administrative action against the officials responsible for approving the restoration of the Director's leave. *(Conduct, Attendance, and Travel Issues, VARO, Portland, OR, 99-01785-14, 12/21/99)*

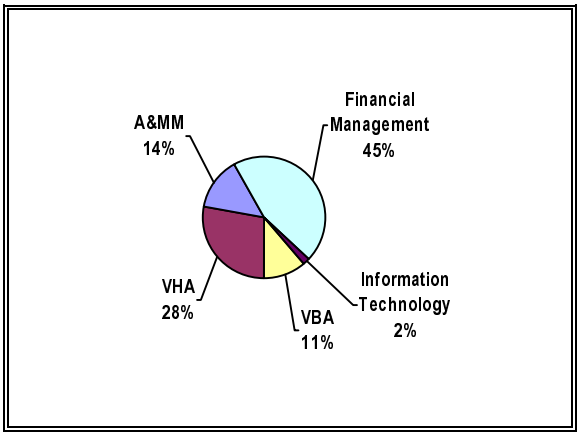
OFFICE OF AUDIT

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, effectiveness, efficiency, financial, and internal control of VA operations, and that identify constructive solutions and opportunities for improvement, and to conduct preaward and postaward reviews to assist contracting officers in price negotiations and to ensure reasonableness of contract prices.

Resources

The Office of Audit had an average 154 FTE assigned in VA Central Office and 5 operating divisions throughout the country during the 6-month period covered by this report. The following chart shows the percentage of resources utilized in auditing each of VA's major program areas.



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

Overall Performance

Output

- Issued 16 performance and financial audits and evaluations, for an output efficiency of 1 report per 4.8 FTE during this 6-month period. Additionally, 16 contract review reports (7 preaward contract reviews and 9 postaward reviews) were issued, for an output efficiency of about 1 report per FTE for the 6-month period.

Outcome

- Recommendations were made to enhance operations and correct operating deficiencies with monetary benefits totaling $189.7 million. In addition, contract reviews identified monetary benefits associated with preaward and postaward contract reviews of $23.8 million.

Cost Effectiveness

- A return of $25 in monetary benefits was achieved for every dollar spent in performance and financial audits and evaluations during this 6-month period. A return of $19 in monetary benefits was achieved for every dollar spent on contract reviews. Additionally, contract reviews resulted in 64 percent of recommended better use of funds being sustained by the contracting officer during negotiations.

Customer Satisfaction

- Customer satisfaction with performance and financial audits and evaluations was 4.4 on a scale of 5, for reports issued during the period. The average customer satisfaction rating for contract reviews was 4.5 out of a possible 5.

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

and identified savings that could be used to provide more and better service. The following summarizes some of the audits completed during the reporting period organized by VA component: VHA, VBA, Office of Financial Management, Office of Information Technology, Office of the Secretary, and issues requiring action by multiple offices. This is followed by an assessment of the implementation of GPRA in VA.

Veterans Health Administration

Resource Utilization

Issue: Advanced Food Processing and Delivery Systems (AFPDS).
Conclusion: Centralized food production reduces cost.
Impact: Better use of funds.

We conducted a followup audit of VHA's central food production program and its AFPDS. The purpose of the audit was to determine whether the central food production program implemented in 1998 at VA medical facilities in Dayton, Chillicothe, and Cleveland, Ohio; and in Butler, Pennsylvania, achieved its projected cost savings of about $1.7 million, mostly from staff reductions.

A March 1990 OIG audit report, *Veterans Health Services and Research Administration's Plans for Advanced Food Processing Systems and Advanced Delivery Systems*, recommended the development of central food production programs nationwide. VHA did not concur in the audit conclusion, and cited pilot test results that showed centralized food production could not effectively function in the VA food service environment.

The followup audit showed that Dayton, the central production facility, and the participating remote facilities successfully implemented the central food production program. Facilities achieved expected improvements in food service and realized or exceeded expected staff reductions. While the Dayton program represents a best practice in comparison to traditional systems used by VHA, there is opportunity to further improve the system and optimize cost savings. Additional efficiencies and quality improvements could be achieved by: (i) increasing the number of participating sites, (ii) strengthening management of the program, (iii) consolidating equipment procurement, (iv) monitoring equipment performance, (v) limiting the scope of associated construction projects, and (vi) reducing utility costs. We recommended the Acting Under Secretary for Health use the Dayton advanced food processing and delivery system as a best practice, and analyze, broadcast, and implement the system nationwide, if feasible.

The Acting Under Secretary for Health stated the centralized production system did not meet VHA's definition of a best practice, but he agreed the system did achieve measurable efficiencies. He said Nutrition and Food Service already recommends the system as an option for selected food service operations. He also stated that he would encourage application of the food factory concept in as many other service areas as possible by furnishing each VISN Director a copy of the audit report, and that advanced food processing and delivery systems would be implemented where feasible. (*Audit of Advanced Food Processing and Delivery Systems (AFPDS) in Ohio and Western Pennsylvania, 98-00156-39, 2/9/00)*

Fraud Detection

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

The purpose of the audit was to assist VHA in assessing the risks for abuse, fraud, and unnecessary costs associated with certain types of WCP claims. The audit was completed as part of the OIG's continued effort to enhance the effectiveness of VHA's review and oversight of claims. Specifically, the audit reviewed VHA claims involving the following three high-risk areas:

Dual Benefits – Concurrent payments of VA and WCP compensation benefits for the same injury.

Non-VHA Employee – WCP claimants who were not employed by VHA at time work-related injury occurred.

Deceased WCP Claimants – Deceased WCP claimants whose compensation was not properly terminated or continued entitlement to survivor's benefits was not properly verified.

VHA is a major employer with the largest healthcare system in the United States that provides medical service at over 1,150 facilities. Costs for WCP claims by employees that result from injury sustained in the performance of duty are substantial. Under the Federal Employees Compensation Act injured employees can receive WCP benefit payments for lost wages and for medical treatment for the specific disability associated with the injury. VHA's FY 1999 payment for WCP costs to the Department of Labor (DOL), who administers the Act, will total about $129.2 million dollars and accounts for about 95 percent of the Department's WCP costs. These costs are based upon actual payments made by DOL in charge back year 1997 (July 1996 - June 1997).

The audit found that VHA is vulnerable to abuse, fraud, and unnecessary costs associated with claims in the three high-risk areas reviewed. VHA's management of cases involving these high-risk areas needs to be strengthened to assure the appropriateness of some claims. As a result, VHA incurred unnecessary costs involving claimants who inappropriately received concurrent WCP and VA compensation payments for the same injury. Claimants were also inappropriately paid claims with VHA funds even though they were non-VHA employees at the time injury occurred. Claims involving deceased claimants also needed better follow up and more timely termination action to avoid inappropriate payments. Based on the audit results, we estimate VHA has incurred or will incur about $11.2 million in unnecessary costs associated with claims in these three high-risk areas. Additionally, the audit identified five WCP claims that potentially involved program fraud.

The OIG continues to work with VHA to target program fraud and reduce costs. The OIG is currently developing a fraud awareness pamphlet for distribution to all VHA employees. The report includes recommendations to further strengthen oversight and reduce VHA's costs by ensuring appropriate payment of claims in high-risk areas. The Acting Under Secretary for Health concurred with the recommendations and indicated implementation actions are in process. *(Audit of High-Risk Areas in VHA's WCP, 99-00046-16, 12/21/99)*

Veterans Benefits Administration

Issue: Loan Guaranty Service's (LGS) quality review system.
Conclusion: Service needs to improve its quality control system.
Impact: Assuring program integrity.

In FY 1998, VA reported $70 billion in guarantees outstanding on mortgages with a face value of $203 billion. VA reports it guarantees approximately 300,000 mortgage loans per year. In addition, VA maintains a direct loan portfolio that includes about 29,000 loans with an unpaid principal balance valued at $1.9 billion. LGS provides program policy, procedures, and operating guidance for VA's home loan program.

The purpose of our evaluation was to determine whether LGS had an effective quality review system. We focused on LGS' internal control review and statistical quality control programs as well as the activities of their lender monitoring unit and oversight of the contractor servicing the direct loan portfolio.

We identified several quality control weaknesses that required management attention. Management had not updated their management control plan, which should identify high-risk areas, in over 5 years nor had they completed required internal control reviews of those areas in over 3 years. LGS' recently revised statistical quality control program had not identified a significant number of deficiencies concerning compliance with their policy and procedures. The lender monitoring unit had not issued timely reports identifying loan underwriting deficiencies. Finally, oversight of the contractor servicing VA's direct loans had not ensured that loans were actively serviced, foreclosed when appropriate, or routinely monitored when in a bankruptcy status.

We concluded that LGS needed to improve its quality review system. As LGS reorganizes, and in some instances outsources its activities, it is essential that they maintain program integrity through close oversight of not only their own operations, but those of contractors and program participants as well.

During our evaluation, management took steps, such as clarifying statistical quality control requirements and resuming field station surveys, which should improve their quality review system. We made a series of recommendations to further strengthen quality controls over the loan guaranty program. The Under Secretary for Benefits concurred with the findings and provided acceptable implementation plans. *(Evaluation of Loan Guaranty Service's Quality Review System, 99-00159-42, 2/28/00)*

Office of Financial Management

VA's Financial Statements

Issue: VA's Consolidated Financial Statements (CFS) for FYs 1999 and 1998.
Conclusion: Some assets may not be adequately protected and resources may not be properly controlled.
Impact: Improved stewardship of VA assets and resources.

Our audit report contains the OIG audit opinion and assessment of VA's internal control structure and compliance with laws and regulations. Our audit opinion provides an unqualified opinion on the Department's CFS for FYs 1999 and 1998. Our Report on Internal Control discusses three material weaknesses concerning: (i) VA-wide

information system security controls, (ii) Housing Credit Assistance (HCA) program accounting, and (iii) fund balance with U.S. Treasury reconciliations. The Department made significant improvement to address previously reported information system security controls and HCA program accounting issues. We encourage the Department to continue their efforts and to complete correction of the remaining open information security and HCA recommendations and the new recommendations concerning fund balance with U.S. Treasury reconciliations. These internal control weaknesses expose VA to significant risks and vulnerabilities. The Department reported the information systems security controls and the HCA program accounting issues as material weaknesses in their Federal Managers' Financial Integrity Act (Public Law 97-255) reports for FYs 1999 and 1998. In this report, we reaffirm our prior recommendations and have additional recommendations addressing these weaknesses and the reportable conditions.

Our Report on Compliance with Laws and Regulations discusses the Department's noncompliance with Federal Financial Management Improvement Act (Public Law 104-208) requirements concerning HCA program financial management information systems, information system security, and cost accounting standards. Except for these noncompliances, the report concludes that for the items tested, VA complied with those laws and regulations materially affecting the financial statements. We also continued to identify noncompliance with one law that while not material to the financial statements, warrants disclosure. This is the requirement for charging interest and administrative costs on compensation and pension accounts receivable.

The Assistant Secretary for Financial Management stated the results of the audit will be shared with senior officials in VHA and VBA, as well as other interested VA staff and program managers. Action plans will be developed for correcting each of the three material weaknesses. *(Audit of the Department of Veterans Affairs CFS for FYs 1999 and 1998, 99-00006-46, 3/14/00)*

"Please convey my sincerest appreciation to everyone on your staff who worked so diligently on this year's audit of our financial statements. We commend the efforts of your staff to maintain a balance between cooperation and independence throughout this effort."

Assistant Secretary for Financial Management

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

Correction of noncompliance items is in process for items shown in our report on VA's Consolidated Financial Statements as being noncompliant with FFMIA requirements. VA has taken a number of steps to establish a comprehensive information system security program and established a target date of FY 2003 for completing corrective actions concerning Department-wide information system security weaknesses. Corrective action was completed on previously reported Housing Credit Assistance program credit reform accounting issues, but other areas where HCA financial management information system are noncompliant have target dates for completing corrective actions throughout FY 2000. Previously reported target dates for completing implementation of systems to fully comply with

managerial cost accounting requirements changed from FY 1999 to FY 2000 for NCA and FY 2000 to FY 2001 for VHA.

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

As part of the CFS audit, we issued three management letters addressing financial reporting and control issues. The management letters provided Department managers additional observations and advice that will enable the Department to improve accounting operations and controls. These issues included: (i) fund balance with Treasury, (ii) application of agreed-upon procedures, and (iii) automated data processing security.

None of the conditions noted had a material effect on the FY 1998 CFS, but correction of the conditions was considered necessary for effective operations. Where needed, appropriate adjustments were made to the financial statements. *((i) Management Letter: Fund Balance with Treasury, Agency Location Code 36-00-12000, 98-00009-2, 10/1/99, (ii) Management Letter: Report on Agreed to Procedures, 99-00008-25, 12/22/99, and (iii) Management Letter: VA's Minimum Password Configuration Policy, 99-00003-33, 1/20/00))*

Issue: Attestation of VA's accounting for FY 1999 expenditures on national drug control program activities.
Conclusion: Estimated obligations reported in FY 1999 are not reliable and all activities conducted by VA having a drug related nexus are not reflected in the drug methodology.
Impact: Financial reporting and control.

21 United States Code, Section 1704 requires that agencies responsible for implementing any aspect of the "National Drug Control Strategy" submit to the Director, Office of National Drug Control Policy, a detailed accounting for all funds expended by the agency for national drug control program activities during the previous year. The statute also requires such accounting be authenticated by the agency's IG prior to submission.

We have reviewed the VA's "Detailed Accounting Submission" for FY 2000 relating to obligations on program activities. We concluded that: (i) estimated obligations reported for FY 1999 are not reliable as a consequence of methodological shortcomings associated with extrapolation of prior year data and unreliability of cost accounting data produced by VA financial systems; and (ii) all activities conducted by VA having a drug related nexus are not reflected in the drug methodology. However, the costs associated with unreported drug-related activities may not be material relative to the aggregate costs reported. (*Attestation of the Department of Veterans Affairs "Detailed Accounting Submission" for FY 2000, 00-00983-41, 2/23/00)*

Postaward Contract Reviews

Issue: Contractor overcharges for pharmaceuticals and medical supplies.
Conclusion: Postaward audits and surveys disclosed overcharges.
Impact: Recovery of $2,283,146.

- We completed four Public Law 102-585 compliance reviews at pharmaceutical companies. For three of the four companies, we discovered errors in the calculation of Federal ceiling prices that resulted in contract overcharges. The companies agreed to pay $1,785,816 to VA. We also made

recommendations to all of the companies reviewed suggesting ways they could improve their policies and procedures so that the Government and the companies could be assured their systems were producing accurate Federal Ceiling Prices.

- A medical supply company remitted $495,550 to VA for contract overcharges resulting from not disclosing accurate, complete, and current pricing and discount information to the contracting officer during negotiations. The company also failed to comply with the provisions of the contract's price reduction clause. The company's failure to disclose their most favored customer discounts denied the Government the opportunity to negotiate more favorable discounts, and their failure to disclose price reductions to their comparable commercial customer denied the Government their contractual right to the better prices.

- A medical supply company made a voluntary disclosure and refund offer of $1,656 to VA to correct price reduction violations on the contact. Our review showed the overcharges amounted to $1,780, which the company remitted to VA.

Issue: VA claim against a bonding company.
Conclusion: VA overpaid for work performed by a contractor terminated for default.
Impact: Recovery of $265,792.

The VA directed a bonding company to release $265,792 to a contractor for work completed on a major construction project at a VAMC. Our review disclosed the VA inadvertently overpaid the bonding company for completed work by a predecessor contractor which the VA had terminated for default.

Preaward Contract Reviews

Issue: Federal Supply Schedule vendors did not always offer best prices.
Conclusion: Contractors can offer better prices to VA.
Impact: Potential better use of $20,533,527.

- A preaward review of a pharmaceutical company's offer resulted in potential savings of $18,747,758.

- Preaward reviews of two wheelchair manufacturers' offers resulted in potential savings of $1,785,769.

Issue: Healthcare resource contracts.
Conclusion: The VA has opportunities to negotiate reduced contract values.
Impact: Potential better use of $451,945.

- A preaward review of a proposal for scarce medical specialists services concluded the contracting officer should negotiate reductions to the proposed contract costs amounting to $334,945. Another preaward review of a scarce medical specialists services' proposal concluded the format of the contract was not in the best interest of the VA and recommended the solicitation be reissued using an FTE format.

- A preaward review of a proposal for ambulance services resulted in savings of $70,000.

Office of Congressional Affairs

Issue: Allegations concerning the Office of Congressional Affairs (OCA).
Conclusion: Action is needed to improve the operation and management of OCA and ensure a more effective work environment.
Impact: Improved management of OCA.

We substantiated the allegations received through the OIG Hotline and during the audit. OCA salary and expense accounts were over-expended by almost $390,000 in FY 1999. The accounts were over-expended by hiring consultants and temporary employees, and executing a reimbursable interagency work detail, without sufficient funds in the approved budget. OCA exceeded its FY 1999 travel budget and travel expenditures lacked adequate justification to assess whether performance was consistent with OCA's mission and strategic goals because OCA did not require written justification, such as trip reports to support travel costs. We also found the budget, fiscal, and management controls were not effectively established or communicated to all staff to ensure accountability and prevent employee abuses.

Overall, we found a polarization exists between a group of new hires and consultants with VA career staff working in OCA. We found that OCA staff morale is extremely low and there is a strong sense of mistrust for the former Principal Deputy Assistant Secretary (PDAS) for OCA and fear of retaliation on the part of the VA staff. Based on our interviews we conducted and our observations, we also concluded there has been an ineffective use of staff resources in OCA. New leadership strategies are needed to address the polarized work environment in OCA and to eliminate perceptions of favoritism.

We concluded the organizational change directed by the VA Secretary was not implemented effectively or timely by the former PDAS. The former PDAS did not follow Department policies and procedures for implementing a major reorganization. Nor were actions taken to ensure a budget increase was properly approved and executed for OCA in recognition of increased organizational responsibilities. As a result of OCA not following the prescribed policies and procedures, the adverse impact of budget reductions to other VA staff offices was never appropriately addressed. The Assistant Secretary for Planning and Analysis concurred with the report recommendations to improve the operation and management of OCA. *(Audit of Allegations Concerning the VA OCA, 99-00055-12, 1/7/00, and Addendum Report: Audit of Allegations Concerning the VA OCA, 99-00055-47, 3/22/00)*

"I appreciate the professionalism your office has demonstrated throughout the process."

Assistant Secretary for Planning and Analysis

VA Congressional Office headline

[photo not available electronically]

Office of the Secretary

Issue: Allegations of use of travel, representation funds, and motor vehicles with respect to the Secretary.

Conclusion: The Secretary's office did not abide by applicable regulations.

Impact: Integrity of the Office of Secretary.

The OIG received a series of complaints concerning the Secretary of Veterans Affairs. While a number of the issues addressed the personal preferences of the Secretary or were seemingly a reaction to his style of management compared with previous Department Secretaries, others were potentially more serious in nature. We focused our review primarily on three significant issues: The Secretary's travel expenses, particularly the use of military aircraft; the use of operating funds appropriated for official reception and representation expenses associated with an awards dinner; and the leasing of motor vehicles for the executive motor pool.

We substantiated the allegation that the Secretary improperly used Government (military) aircraft for flights to Alaska and Louisiana. The cost of the Alaska round trip, which included the Secretary and a party of five, was $60,000. In addition to the Secretary's party, a security detail of two was assigned to travel separately to Alaska by commercial air at a round trip cost of $717 each. If the travel of the Secretary and the other five VA employees had also been booked on available commercial aircraft at the same Government rate, their total scheduled airfare would have been $4,302.

The Secretary and three others also traveled round trip by military aircraft to Louisiana at a cost to VA of $3,396. At the time of the report, VA had not received a bill for the return trip. The cost of commercial round trip airfare for the one-person security detail was $236. If the four individuals who traveled on the military aircraft had flown commercial the total cost would have been $944.

The Secretary's office did not abide by applicable OMB and General Service Administration regulations governing use of Government aircraft, nor did the circumstances of the travel justify the use of Government aircraft. We recommended the Secretary should ensure that the appropriate personnel in VA are trained in the provisions of OMB Circular A-126, directed to apply it to the Department use of Government aircraft, document the use of these aircraft, and maintain the document for a period of at least 2 years.

We partially substantiated the allegation that the Secretary inappropriately used VA funds to host an awards dinner for the Secretary of the Navy. The cost of the award to the Navy Secretary's spouse should not have been charged to appropriated funds. While the awards dinner itself may fall within the broad latitude provided for use of official reception and representation funds, the expenditure of nearly one quarter of available funds to recognize a single individual has fueled the perception of waste. This perception was reinforced by the fact that the cost of this awards dinner was $283 per person. In contrast, total expenditures for events like the veterans service officers holiday party and receptions at the White House honoring veterans, who numbered far greater than the number of guests at the awards dinner, were about the same. We recommended that the Secretary should reimburse the Department for the $375 spent on awards for the Navy Secretary's spouse.

The allegation that the Secretary misused official Government vehicles by leasing a Cadillac with certain options was not substantiated.

We discussed the recommendations and conclusions developed during the investigation. We believe the Secretary's comments were responsive to the investigation's recommendations and conclusions. *(Administrative Investigation, Use of Travel, Representation Funds and Motor Vehicles with Respect to the Secretary of Veterans Affairs, 99-00011-3, 10/1/99)*

West headline

[photo not available electronically]

Multiple Office Action

Procurement Issue

Issue: Procurement Initiatives.
Conclusion: Key transition milestones were delayed that caused VA to extend the use of the existing contract that had unfavorable prices and terms, and lacked effective contract administration.
Impact: Better use of more than $147 million.

The purpose of the audit was to: (i) review the Integrated Data Communications Utility (IDCU) contract award, administration, and price reasonableness; (ii) review efforts to replace the IDCU contract and ensure equitable pricing of future work requirements; and (iii) identify areas of high risk to the Department that required attention. While the Department is taking positive steps to transition to a new wide area network, the audit identified issues in the current IDCU contract that adversely impacted VA operations and costs.

The audit found that the IDCU system and contract were no longer meeting VA's telecommunication requirements effectively or efficiently. Key audit finding areas included: (i) contract modifications totaling $142 million were not supported with adequate documentation to explain why the contract increases were fair and reasonable; (ii) VA spent approximately $3.1 million leasing and maintaining an excessive number of unused ports over the life of the contract; (iii) VA needs to recover over $1 million in payments to the contractor for the performance management system that was not accepted; (iv) VA saved $944,891 by terminating the acquisition support contract in response to our audit results; and, (v) VA could save an estimated $60,000 if consultant services were acquired through competitive means.

We also advised the Department that it needed to conduct a formal risk assessment to adequately assess, manage, and mitigate the levels of risk associated with transitioning to a new wide area network solution. In addition, we identified some key business decisions made by the contracting officer at the time the contract was awarded that negatively impacted VA's ability to effectively administer this contract over its 10-year life cycle. The Acting Assistant Secretary for Information and Technology and the Assistant Secretary for Financial Management concurred with the report recommendations directed to their offices and provided appropriate implementation actions. (*Audit of Procurement Initiatives for VA's IDCU Telecommunications Support, 98-00057-1, 10/1 99)*

"Thank you for all the work you and your staff put into this IDCU audit. We believe the results improved the overall operations of this office."

Director, Acquisition Operations and Analysis Service

Supply Inventories

Issue: Prosthetic supply inventories.
Conclusion: VAMCs and the Denver Distribution Center (DDC) could reduce large excess inventories by more effectively using automated inventory management techniques.
Impact: Better use of $31.4 million.

We performed an audit to evaluate how effectively these organizations managed their inventories of prosthetic supplies. In FY 1998, VA prosthetic supply purchases totaled $368 million. At any given time during FY 1999, the value of VA's prosthetic supply inventories was about $61 million. VHA and OA&MM have encouraged VAMCs and the DDC to modernize and improve inventory management. However, VAMCs and the DDC still maintain large prosthetic supply inventories that far exceed requirements for current operating needs. Our audit at five VAMCs with combined prosthetic supply inventories valued at $2.7 million found that about $1.3 million (48 percent) was excess. At the DDC, about $528,000 (49 percent) of the $1.1 million was excess.

At both the VAMCs and the DDC, excess inventories occurred because inventory managers did not adequately monitor stock levels, made unnecessary large quantity purchases, and did not effectively manage reductions in item demand. These deficiencies could have been avoided or mitigated if the VAMCs and the DDC had more effectively used available automated inventory controls. Instead, the VAMCs and the DDC relied on excess inventory as a substitute for aggressive inventory management.

We recommended VHA and OA&MM: (i) require VAMCs and the DDC to establish goals for reducing inventories and to use automation for managing their inventories, (ii) monitor progress in reducing inventories, (iii) encourage the use of alternative procurement methods that help reduce inventories, and (iv) enhance automated inventory management systems to provide needed controls. We estimated that better management could reduce VAMC prosthetic supply inventories by $31 million and DDC inventories by $528,000. The Acting Under Secretary for Health and the Assistant Secretary for Financial Management concurred with the audit recommendations and provided acceptable implementation plans. (*Audit of Management of Prosthetic Supply Inventories at VAMCs and the DDC, 99-00188-13, 11/15/99)*

"Your audit team which conducted the survey at our center was most responsive in answering questions and providing timely results and recommendations. Their conduct was professional and their approach exemplary."

Assistance Secretary for Financial Management

Implementation of GPRA in VA

Congress attaches great importance to effective implementation of the Government Performance and Results Act (GPRA). The OIG has a significant role to play in informing both VA

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

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

Current Status

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

VHA Performance Measures: Prevention index and addiction severity index.

VBA Performance Measure: Foreclosure avoidance through servicing.

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

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

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

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

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

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

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

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

OFFICE OF HEALTHCARE INSPECTIONS

Mission Statement

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

Resources

The Office of Healthcare Inspections (OHI) has 34 FTE assigned to staff headquarters and field operations. To better utilize our staff in carrying out the mission of the office, the OIG established five OHI regional offices nationwide. OHI inspectors commit all of their staff time to healthcare inspections and evaluation issues.

Overall Performance

Output

- We published 6 final reports during the reporting period.

- We also provided oversight of 59 cases on inquiries sent to VHA program offices and the Medical Inspector for review and disposition action.

Outcome

- We made 12 recommendations, focused on improving both clinical care delivery and management efficiency.

Customer Satisfaction

- Program managers' satisfaction and acceptance level of our work was an average of 4.6 on a 5.0 scale for the year.

Veterans Health Administration

Nationwide Healthcare Program Reviews

Issue: Management and coordination of the Hepatitis C virus initiative.
Conclusion: Hepatitis C risk evaluation and screening mechanisms need improvement.
Impact: Better management and care of veterans who require care.

In response to a request from the House Committee on Veterans' Affairs, we conducted an evaluation of the treatment of veterans who require hepatitis C virus (HCV) care in VHA medical facilities. We reviewed: (i) VA's practice of prescribing combination drug therapy for patients when indicated, and whether any VA entity rations HCV treatment; (ii) if there are problems with the timely administration of the combination drug therapy; (iii) who instructed a physician at a VAMC to ration treatment to veterans under his care; and (iv) if this direction was given from VA's headquarters or the responsible VISN office.

We did not find any evidence of HCV treatment rationing at the eight VAMCs that we inspected. All of the clinicians whom we interviewed indicated that they had all of the necessary means to test, evaluate, and treat patients. During the course of the evaluation, we became aware of a situation at a VAMC in which not all of the veterans who needed therapy may have received it promptly due to fiscal constraints. The VISN director promptly remedied that situation after he became aware of it. VAMC managers and clinicians whom we interviewed denied that VHA or VISN officials had ever negatively influenced their efforts to

accommodate the rapidly growing workload. VHA issued treatment guidelines and has provided forums for ongoing clinical education and guidance. VHA issued directions that all veterans seeking care in a VHA facility are to be evaluated for HCV risk. However, we found this requirement is not fully implemented because VAMCs are not uniformly screening all veterans who seek care. Some facilities did not have any risk factor screening procedures for new patients.

While VHA's full implementation of the HCV initiative will take time, uniformity of risk-evaluation and screening mechanisms needs to be addressed soon. The impact of HCV-related workload is an increasing concern to managers in VHA facilities. VAMC managers and clinicians whom we interviewed, unanimously expressed their concerns to us about the anticipated impact on their facilities' resources, and particularly about their future abilities to treat all of the veterans who are expected to seek care and treatment of HCV.

We recommended VHA conduct a cooperative study at multiple facilities to refine and improve HCV care and treatment. We also recommended VHA establish a sponsored national policy or advisory board that would include nationally recognized clinical experts in the field. The Acting Under Secretary for Health concurred in principle or with qualification on the report recommendations. We will continue to work with the VHA staff on these issues. *(Evaluation of the Department of Veterans Affairs VHA Hepatitis C Initiative, 99-00764-4, 10/15/99)*

Healthcare Hotline Inspections

Issue: Administration and oversight of the radiation safety program and the Research Service.

Conclusion: The VAMC's Research Service and the Human Studies Sub-committee have been diligent and conscientious in the oversight of research using human subjects.

Impact: Ability to ensure patient safety in research studies.

A complainant alleged several research improprieties and improper use of informed consent. The complainant also alleged that inappropriate constraints were placed on the role and responsibilities of the radiation safety officer. OHI inspectors reviewed these and other alleged research improprieties, and during the course of the inspection, issues arose that were related to the use of informed consent forms and their present content. We also identified a serious matter concerning the lack of confidentiality and privacy of human subject research records.

OHI inspectors were unable to substantiate the allegations of research improprieties and the concerns about the improperly managed informed consents. In particular, the four research projects that the complainant identified as suspect were conducted according to all of the pertinent regulations governing the conduct of research on human subjects. However, the informed consent forms, while appropriate, needed to be updated, consistent with applicable prevailing standards and policy. Inspectors identified several violations of confidentiality and privacy of patient records and research documents. Specific actions are needed to protect these sensitive records from inappropriate disclosures. Finally, we determined that the radiation safety officer has an appropriate scope of duties. His responsibilities are consonant with the pertinent guidance and regulations promulgated by the Nuclear Regulatory Commission and the VA.

We made three recommendations. The Medical Center Director concurred with the recommendations and has taken action to update the informed consent forms. The other two

recommendations are unimplemented pending the receipt of information on plans to conduct an investigation of the issues of privacy and confidentiality and our receipt of the investigative report. (*Alleged Research Improprieties and Informed Consent Issues, Jerry L. Pettis Memorial Veterans Hospital, Loma Linda, CA, 97-00680-6, 10/7/99*)

Issue: Allegations of substandard care and a "cover-up."
Conclusion: Inspectors identified lapses in care.
Impact: Increased collaboration between physicians taking care of surgical patients and the medical consultants for those patients.

We reviewed allegations of substandard care provided to a patient at VAMC Miami, and an alleged "cover-up" of these deficiencies. We concluded there were indeed lapses in the patient's care and the documentation of his care in the medical record, and we delineated those issues in our report. Nevertheless, the medical record does not establish that these lapses in care were mainly responsible for the patient's death, as alleged. Overall, there is not a clear cause and effect relationship between care and documentation lapses, and the medical and surgical emergencies, which led ultimately to the patient's death. We also found that correspondence with the patient's family, which generally reassures the patient's family that care was good, did not always correlate with the internal findings and recommendations of a very thorough quality assurance review and a board of investigation, both of which were performed to assess the patient's care. This may have left the unfortunate impression of a "cover-up."

We recommended the Medical Center Director continue to aggressively emphasize close collaboration between physicians taking care of surgical patients and the patients' medical consultants. The Medical Center Director concurred with this recommendation, and implemented acceptable action plans. (*Inspection of Alleged Substandard Patient Care, VAMC Miami, FL, 98-00501-7, 10/28/99)*

"This was an extremely difficult and complex situation …. OHI's thorough review and analysis of this case was highly professional and brought the matter to closure."

Miami Medical Center Director

Issue: Alleged substandard care.
Conclusion: Clinicians should have stabilized the patient in the Emergency Room and transferred him to a trauma center.
Impact: Strengthened admission policies.

A complainant alleged her father died at the James A. Haley Veterans Hospital because he received substandard care after being involved in a serious car accident.

We concluded that, fundamentally, an elderly patient who had numerous existing medical problems, was not an appropriate admission to the hospital despite the outstanding credentials of the clinical providers. The patient had sustained multiple injuries as a result of an automobile accident of such severity that the patient had to be extricated from his vehicle.

The Medical Center Director disagreed with several points in our review, regarding such issues as the stability of the patient. We believe these are areas of differing clinical interpretation and judgment. We made a two-part consultative recommendation and the Director fully addressed all issues. *(Inspection of Alleged Inadequate Trauma Treatment, James A. Haley Memorial Hospital, Tampa, FL, 98-00600-10, 11/4/99)*

Issue: Domiciliary care program.
Conclusion: Improvements were needed to provide a safer environment for patients and employees.
Impact: Improved domiciliary operations.

A veteran, who was a resident in the VAMC Biloxi domiciliary substance abuse treatment aftercare program, stabbed to death two other veterans who had been discharged from the domiciliary earlier in the year. The incident reportedly occurred during an apparent drug exchange in a private parking lot across the street from the VAMC grounds. We conducted an on-site review of the domiciliary operations, including the aftercare program, in order to determine if this violent act involving drugs was an isolated incident or if it represented a possible need for improvement in safety measures.

We found that, at the time of our inspection, the Director and her senior staff had not implemented or otherwise addressed previous recommendations, aimed at improving domiciliary operations, made by internal reviewers. We also found communications and coordination between the Gulfport substance abuse residential rehabilitation treatment program and the domiciliary aftercare program were not effective and nearly non-existent.

We concluded management needed to strengthen domiciliary controls for ensuring that patients and employees are safe, and to provide a more effective therapeutic environment in the aftercare program. Clinical managers of the extended care and mental health product lines needed to further develop and implement plans to maximize the coordination and continuity of the two phases of substance abuse treatment. Domiciliary employees at all levels should have input into this process.

The Medical Center Director concurred with the recommendations and provided responsive implementation plans. *(Inspection of Allegedly Unexpected Patient Deaths and Review of Domiciliary Operations, VAMC Biloxi, MS, 99-00623-19, 1/20/00)*

Issue: Alleged inappropriate plastic surgery.
Conclusion: Surgeons acted properly in performing surgery.
Impact: Appropriate use of surgical resources.

A complainant alleged a patient received plastic surgery primarily for cosmetic and aesthetic reasons, and the surgery was performed in order for physicians-in-training to obtain experience in the procedure. In conducting this VAMC review we addressed numerous other concerns alleging the inappropriate performance of plastic surgery procedures. These concerns focused on both the specifically referenced patient, as well as the plastic surgery section in general.

We concluded the primary indication for the patient's plastic surgery was a traumatically incurred nasal obstruction in conjunction with facial distortion. These conditions, in combination, produced symptomatic upper airway pathology. While the patient may have achieved some incidental and secondary cosmetic benefits from the surgical procedures, the primary indications were medical. We also reviewed the indications for all operations credited to the plastic surgery section in FY 1999. All 134 plastic surgery procedures performed were permissible under applicable VA regulations.

The Medical Center Director concurred with our recommendations and implemented appropriate corrective actions. (*Inspection of Alleged Inappropriate Plastic Surgery, VAMC Washington, DC, 99-00859-36, 2/22/00)*

OFFICE OF MANAGEMENT & ADMINISTRATION

Mission Statement

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

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

I. Hotline and Data Analysis Division - The Division is responsible for determining action to be taken on allegations received by the OIG Hotline. The Hotline section receives thousands of contacts annually, mostly from veterans, VA employees, and Congressional sources. The work includes controlling and referring many cases to impartial VA components having jurisdiction. The Data Analysis section provides automated data processing support, such as computer matching and data extraction from VA data bases.

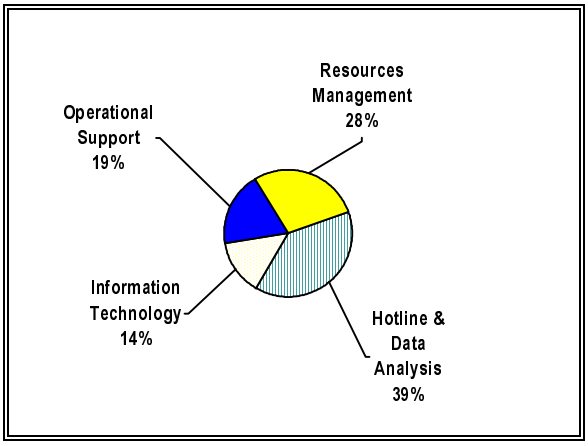
II. Operational Support Division - The Division does followup tracking of OIG report recommendations; Freedom of Information Act releases; strategic, operational, and performance planning; and IG reporting and policy development.

III. Information Technology Division - The Division manages nationwide information technology support, systems development and integration, and represents the OIG on numerous intra- and inter-agency organizations and does strategic planning for all OIG information technology requirements. The Division also provides statistical support services to all OIG components and maintains the Master Case Index (MCI) system, the OIG's primary information system for case management and decision making.

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

Resources

The Office of Management and Administration has 51 FTE allocated to the following areas.



I. HOTLINE AND DATA ANALYSIS DIVISION

Mission Statement

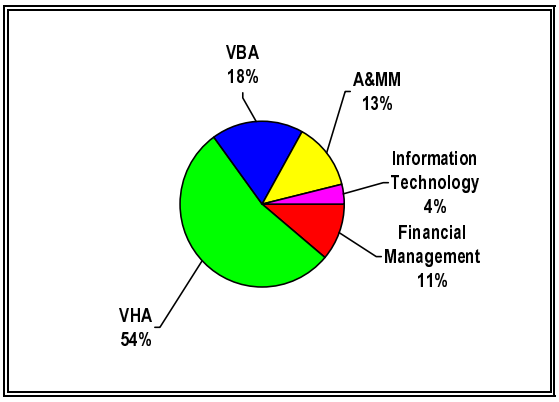
Ensures that allegations of fraud, waste, abuse, and mismanagement are responded to in an efficient and effective manner. Provides automated data processing technical support to all elements of the OIG and other Federal Government agencies needing information from VA files.

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

The Data Analysis section provides automated data processing technical support to all elements of the OIG, and other Federal and governmental agencies needing information from VA files. The section is physically located at the VA Automation Center in Austin, Texas.

Resources

There are 20 staff positions allocated to Hotline and Data Analysis Division. In addition to the Division director, there are 11 employees in the Hotline section, and 8 employees in the Data Analysis section, which provides support to all OIG operating elements. The following chart shows the percent of resources utilized by various program areas.



Overall Performance

During the reporting period the Hotline received 7,452 contacts. Of this number, 438 cases were opened. The OIG reviewed 206 of these and the remaining 232 cases were referred to VA program offices for review.

Output

- During the reporting period, Hotline staff closed 256 cases, of which 79 contained substantiated allegations (31 percent). The Hotline staff opened 38 cases and generated 136 letters responding to inquiries received from members of the Senate and House of Representatives.

Outcome

- VA managers imposed 39 administrative sanctions against employees and took 40 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled $1,695,283. Data Analysis staff's support work with other OIG elements resulted in $2.8 million in recoveries for the Government.

A. HOTLINE SECTION

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

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

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

Veterans Health Administration

Employee Misconduct

- A VAMC review substantiated allegations of threats of physical violence, creation of a hostile work environment, use of profane language, and harassment towards a nutrition and food service employee by four of her co-workers. VAMC management suspended one employee for 14 days, another for 10 days, and another for 5 days. One other employee received a reprimand.

- A VAMC review resulted in a substantiated allegation regarding misuse of a Government vehicle. The acting chief, police and security service allowed an employee who had worked overtime to be driven in a Government vehicle to his parked car. The new police chief counseled the former acting chief, a lieutenant in the police service, on the proper use of a Government vehicle.

- A VAMC review substantiated allegations of employee misconduct. A financial resources management supervisor was admonished for soliciting contributions from her subordinates for a "bosses day" gift. The manager of the office was admonished for accepting the gift purchased with the solicited contributions. The manager reimbursed the employees who contributed money for the gift. Both supervisors were counseled on ethics rules related to gifts.

- A VAMC review substantiated the allegation that an employee displayed religious pictures, crucifixes, and symbols on the walls of his office. Management counseled the employee and directed him to remove any religious icons or pictures from the walls of his office**.**

- A VAMC review substantiated an allegation of vehicle misuse. An assistant chief directed a subordinate to transport a sick coworker to a local hospital in a Government vehicle. The assistant chief received a 30-day suspension.

- A Hotline-prompted VAMC board of investigation substantiated misconduct allegations against two engineering service supervisors. One supervisor used profanity and made derogatory statements towards an employee. Management disciplined the supervisor. The other supervisor was found to have misused a Government vehicle and abused his leave. That supervisor was suspended for 39 days and was given a last chance agreement. He subsequently failed to adhere to the agreement and resigned after being given a notice of removal.

- A VISN review conducted by a regional counsel substantiated conflict of interest and other ethical violation allegations involving a VAMC service chief. The review found the service chief had been inappropriately detailed for a 2-year period to a non-profit organization that was building a VAMC guesthouse. As a result, management terminated the service chief's detail and counseled him for his fund raising activities for the non-profit guesthouse.

- A VAMC review at a satellite outpatient clinic substantiated allegations of employee misconduct and time and attendance abuse. The review found employees brought children and pets to work and took extended lunch breaks. VAMC management revised clinic policies and communicated the new policies to all employees.

- A VAMC review found an employee misused her Government e-mail account. The employee distributed a chain-letter message VA-wide using the Government email system. In order to prevent future occurrences, VAMC management issued a memorandum regarding the use of electronic mail. Management also counseled the employee who initiated the chain-letter e-mail.

- A review at a VAMC substantiated an allegation of misuse of a VA e-mail account by a probationary employee. The employee was using her e-mail to harass a former VAMC patient. Management terminated the employee.

- A VAMC review found that a proposed reorganization of the engineering service could have resulted in retaliatory demotion of a service supervisor. Based on this finding, the VAMC cancelled the reorganization and counseled the chief of engineering.

Quality of Care

- A VAMC review prompted by a Hotline inquiry found that a physician assistant had improperly completed a state application for handicapped parking for a veteran, when a physician should have completed it. The review also found the pharmacy misspelled the doctor's name on a veteran's prescription. The physician assistants in the surgical service and the pharmacy employees were counseled on these errors. Additionally, based on the review's findings, the nurse manager discussed with her staff corrective actions regarding staff attitude, professionalism, food tray issues, linen, and medication.

- A VAMC review substantiated an allegation that a veteran was prescribed the wrong medication by a VA nurse practitioner. The pharmacy manager cancelled the prescription and the incident was reported.

- A VAMC admitted that dental patients were experiencing unreasonable delays in treatment due to a decision to close a satellite dental clinic and shift resources to the VAMC. Management decided to reopen the clinic and staff it with a part-time dentist, a hygienist, and a dental assistant.

- A VAMC review found that two VAMC nurses failed to consult with a veteran's physician prior to providing the state with a medical statement regarding the veteran's driving privileges. As a result, the veteran's driver's license was revoked. The VAMC management counseled the nurses and worked with the state to have the veteran's driving privileges restored.

- A VAMC found a patient was improperly prescribed a drug even though his chart clearly indicated he was allergic to the drug. Neither the prescribing doctor nor the pharmacist noted the error. The VAMC instituted training for all

clinical staff initiated to prevent a recurrence of this error.

- A VAMC review substantiated the allegation of negligence in the handling of a patient's medical records. The review determined clinical staff allowed the patient to carry his progress notes to his next scheduled clinic stop, without placing the material in a sealed envelope. The facility is re-emphasizing medical record confidentiality and providing release of information training to staff.

- A VAMC review substantiated an alleged patient safety violation. The review found a wheelchair-confined veteran had been trapped between the automatic doors of the medical center. The incident was immediately reported to the safety officer, who had the door delay and sensitivity adjusted to give wheelchair patients or patients with limited mobility more time to get through the doors.

- A VAMC review found that poor communications with a patient and his family and the failure to report a potentially volatile situation to VA police in a timely manner contributed to a brawl between the patient, his spouse, and VAMC employees. Admissions procedures have been amended to include written explanation of patient rights, and staff will review policies regarding admissions, communications, boundaries, responsibilities, and issues of chain of command.

- A review determined a patient's daughter experienced unnecessary delays in having her father transferred to a VAMC. The VAMC's management revised their patient transfer policy to prevent recurrence of this problem.

- A VAMC review substantiated a safety allegation concerning a patient who fell out of his bed as a result of a stroke. The fall did not cause injury to the patient; however, the review team identified opportunities to improve processes and documentation. A fall prevention program, developed for long term care, was implemented in the acute care area.

- A VAMC confirmed a veteran was improperly billed for medical services. The medical center has issued an $800 credit to the veteran and a letter of apology for the error.

Diversion of Funds

- A Hotline prompted review found a VAMC failed to transfer user fees to the U.S. Treasury as required by VA policy. A VISN audit conducted at the request of the Hotline found that for the past five years, the VAMC had collected $38,650 in user fees from movie and television production companies. The VISN ordered the VAMC to comply with VA policy and transfer the fees to the U.S. Treasury as required.

- A VHA review resulted in partly substantiating an allegation regarding the diversion of funds. The acting chief information office's review found that $1.6 million had been inappropriately diverted into their budget instead of being returned to VHA. The funds were returned to the VHA budget and new oversight processes were established to prevent recurrence. The $1.6 million returned to the VHA budget represents funds that could be better used for patient care.

Government Equipment and Supplies

- A VAMC review substantiated an allegation that a supervisor misused an employee's Government credit card. The chief, voluntary service, signed the credit card receipt in lieu of her secretary. The supervisor was counseled.

- A VAMC review found a machine shop foreman was using Government equipment to make parts for his private airplane. However, he used his own materials and did the work on his

own time. Management counseled the foreman about using Government equipment for his personal use.

- A Hotline referral to a VAMC resulted in a finding that a VA periodontist violated the standards of ethical conduct for employees of the executive branch when he took home professional samples. Upon being made aware that his actions constituted an ethics violation, the periodontist returned the items. Management counseled the periodontist.

- An investigation at a VAMC found that procedures used to ship cans of a dietary supplement from a Consolidated Mail-Out Pharmacy could have resulted in damage to the contents of the package. Shipping procedures were altered to further reinforce packages containing cans of dietary supplement.

- A VISN review at a VAMC substantiated allegations that an $80,000 densitometry machine had been largely unused for nearly a year. The chief of radiology service at that time removed the one individual who had been performing these tests. A new chief, radiology service, was hired and made arrangements for the tests to be performed at another hospital until the services could be reinstituted at the VAMC. The studies were reinstituted at the VAMC and continue to be available at the other hospital for convenience of the patients. In addition, the VAMC has initiated site training for employees to ensure appropriate coverage.

- A VAMC review substantiated an allegation that a shift supervisor was stealing oxygen from oxygen tanks held in storage. The supervisor indicated he was attempting to alleviate symptoms of migraine headaches. The employee was given a written counseling and advised that in future he should seek assistance from the employee health unit.

- A VAMC found the chief, respiratory therapy, had inadequately supervised procurement-related activities in his office. As a result, management established new inventory measures and changed purchasing procedures to avoid the appearance of procurement improprieties. The chief was counseled on his procurement responsibilities.

- A VAMC review concluded a volunteer driver may have operated a Government vehicle in an unsafe manner and nearly injured a pedestrian. As a result, the voluntary service director terminated the volunteer driver's assignment.

Outside Employment

A Hotline-prompted review confirmed allegations that VAMC staff performed work for a non-profit research foundation while on VA time and used VA supplies. VAMC management counseled the supervisor and an employee for misusing Government property and time.

Contracting Activity

- A VISN inquiry substantiated an allegation that a home health care aide did not receive payment for services rendered. A check for $2,052 was issued to the home health care aide.

- A VAMC review substantiated an alleged false claim by a contractor. A veteran referred to the affiliated university hospital by the VAMC was subsequently billed by the university for a procedure paid for by the VA. The university also referred the veteran to a collection agency for non-payment. The VA issued a letter to the contractor advising that such third party billing is not allowed. Additionally, the VAMC issued a letter of apology to the veteran and sent a copy of all correspondence to the collection agency.

Personnel Violations

A VAMC review found that because of staff shortages, a volunteer was covering the patients' library. VAMC management acted to ensure that a library employee is always present if either the patients' library or the medical library is open. However, if either library cannot be staffed on a given day, one library may have to be closed.

Ethical Improprieties

A VHA review found that the participation of high level VA Central Office and VHA officials in quarterly receptions hosted and paid for by various veterans service organizations created the appearance of a conflict of interest and a potential violation of ethical conduct standards. As a result, management terminated the practice of requesting veterans service organizations to host receptions for the senior VA officials.

Veterans Benefits Administration

Receipt of VA Benefits

- A VARO review found that a VA pensioner failed to properly report income to the VA. A VA field examiner determined the pensioner was a part owner of a business. When the veteran failed to produce copies of his Federal income tax statements on request, the VARO terminated the veteran's pension benefits retroactive to November 1998. This resulted in an overpayment of approximately $21,563.

- A VARO reevaluated an earlier decision to withhold payment from a veteran for a class that had been successfully completed and reimbursed the veteran $1,700.

- A VARO field examiner concluded a veteran's funds were being mismanaged by his son, the VA fiduciary. The VARO appointed a new fiduciary for the veteran.

- A VARO review found a veteran continued to receive additional compensation benefits for his ex-spouse after they were divorced. The veteran's ex-spouse was removed from his award when the veteran failed to respond to the VARO's due process letter. The veteran was assessed an overpayment of $3,075.

Benefits Payments to Incarcerated Veterans

A VARO investigation substantiated the allegation that a veteran is receiving compensation benefits while incarcerated. The veteran's benefits will be reduced, resulting in a savings to the Government of $18,495 over the length of the incarceration.

Privacy Issues

A VARO review substantiated a Privacy Act violation. The VARO mailed the complainant his own records and those belonging to a second veteran. In addition, the envelope that contained the records was not sealed. The supervisor and his seven employees in the VARO's Privacy Act office were counseled to adhere to procedures and to make sure all envelopes are sealed securely.

Customer Service

A Hotline inquiry to the VA Debt Management Center found that an employee may have been overly aggressive in trying to collect a debt. The employee was reminded of his customer service responsibilities and was counseled to avoid argumentative or threatening statements.

Office of Human Resources and Administration

Prompted by a Hotline inquiry, an Office of Resolution Management review found that an equal employment opportunity counselor provided written advice to a private sector employee about a situation unrelated to VA. The employee was counseled.

B. DATA ANALYSIS SECTION

The Data Analysis section conducts reviews of VA computerized data files and reports conditions in VA computer systems. Data Analysis staff searches for data and indicators of fraud, waste, and abuse. They also identify data inconsistencies that may indicate the existence of invalid or erroneous information in VA files. These efforts are often the first step in identifying issues warranting comprehensive reviews by other OIG elements.

During the reporting period, the section completed work on 240 requests for information received from OIG operational elements. In conjunction with these requests, the staff worked closely with investigators, auditors, and healthcare inspectors, requesting information to ensure the data was valid, complete, and met their needs. The support work provided by the staff is reported in many of the projects and investigative cases described in other sections of this report.

The Data Analysis section worked closely with OIG auditors and healthcare specialists to develop 26 computer reports and extracts that can be used to assess the overall effectiveness and efficiency of core VAMC operational areas. These core areas are the VAMC departments and services that are critical to the ability to provide veterans with quality health care.

The section also completed support work on 116 requests received from OIG auditors conducting postaward and preaward contract reviews of private sector vendors doing business with the VA. In addition, the section completed support work on 116 requests received from OIG sector vendors doing business with the VA. The reviews resulted in recoveries of $2.8 million returned to the VA supply fund and recommendations that could assist contracting officers in saving $21 million in contract costs.

Some notable examples of the work Data Analysis section staff performed follow:

- One postaward review revealed the company under review could not identify records of sales made under the Federal Supply Schedule for 1994 and 1995. While under different ownership during that time, the company had not recorded contract numbers on their sales records. The staff was able to identify most of the records by matching sales made after 1995 to sales made during 1994 and 1995, extracting the contract numbers, and embedding them in the records. As a result, the auditors were able to include the sales made during these two years into their review.

- A postaward review required obtaining the sales records from a company that operated an old computer system with obsolete computer tapes. The staff researched and found a computer system that was able to process the tapes and convert them to a format that could be processed on VA computer mainframes. As a result, the auditors were able to complete their review of this company's sales.

- The staff also assisted with several Hotline requests involving supply and contracting issues. One notable request was for information on grave markers purchased by VA from four

private vendors. The staff researched all VA financial systems and found purchase orders and Government credit card purchases that were instrumental in resolving the allegations.

- The staff received a request to determine if VA had paid certain invoices to a particular vendor that had filed a claim against the VA for lack of payment. The staff discovered double billing and other irregularities on the part of the company. As a result, the VA was able to stop payments on some of the charges.

- The staff obtained copies of VA's prime vendor file from the Pharmacy Benefits Management office quarterly. The file contains records of all VA pharmaceutical sales by the vendor. The vendor announced extensive changes to its database. The staff kept up with these changes and developed methods of accessing the file so IG auditors could track VA pharmaceutical purchases more accurately.

Other Federal Agencies

- The staff developed six computer profiles to detect potential fraud in VBA systems, and worked closely with the VBA Financial Systems Quality Assurance Service to test these profiles at two VAROs. As a result of these collaborative reviews, eight cases of potential fraud were referred to OIG investigators for further review during this reporting period.

- The staff also completed work on 30 requests received from VA management and other Federal agencies. Most notable were the Department of Defense request for information on the "No Gun Ri" or "Nukuen Ri" inquiry, and the VA General Counsel's request for retention of all VA files containing information critical to the Government's pending tobacco industry litigation.

Requests from VA

- The VHA Data Management Office requested the computer files we developed in support of VA's consolidated financial statements audit. VHA found these reports to be a useful management tool for reconciling VA Central Office accounts receivable with accounts receivable at the 154 VAMCs. Fulfillment of the request requires a national download from all VA hospitals and reconciliation run using VA centralized files. We are providing this service until VHA can assume responsibility for the programs and files needed and incorporate the execution of this task as part of their normal production processing.

- For 4 years, we provided copies of the VBA compensation and pension master file to the VBA Austin Benefits Systems Development Center monthly. VBA needs this information to determine future liabilities for compensation and pension payments. This project has been turned over to VBA.

Computer Profiles to Detect Fraud

- The section redesigned the computerized death match profile to include additional information useful to investigators reviewing cases for potential fraud. These new data include the person's home address, bank number, and bank account number.

- The section identified weaknesses in VBA computer files that render certain groups of records difficult or impossible to review. Social Security numbers were missing from files for veterans who were 100 years of age or older. Social Security numbers, dates of birth and original award dates were missing from records of some veterans receiving VA benefit checks.

- The section developed a set of computer programs to analyze data recorded on VA files to detect veterans receiving duplicate VA

benefits under a VA claim number and a social security number. These cases were referred to OIG investigations staff for further review.

- The section referred a number of cases to OIG investigations where matching with SSA files showed that VA was issuing benefits checks in the names of deceased veterans. At two VA facilities alone, the referrals resulted in $650,000 in recoveries and projected cost savings to VA of $1.3 million.

Computer Errors or Conditions in VA Files Warranting Further Review

- The section identified and analyzed VA benefit records of dependent children whose dates of birth indicates they are 100 years old or older. These records are considered to contain potential errors and should be reviewed by VBA for correction.

- The section also identified VA benefit records where the payee's Social Security number also matches that of a deceased veteran listed in the VA file. No computer match is currently available to identify these cases for potential fraud, which could result in VA payments continuing long after the veteran payee's death.

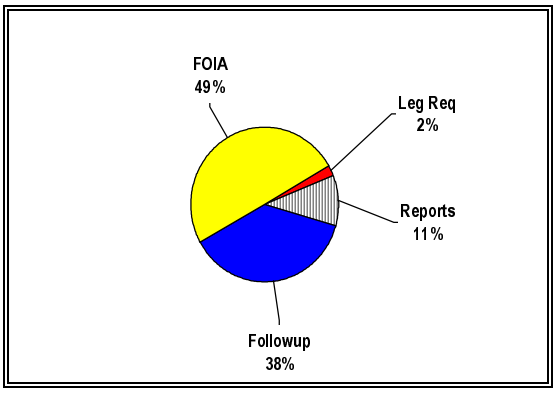
II. OPERATIONAL SUPPORT DIVISION

Mission Statement

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

Resources

This Division has 8 FTE with the following allocation:



Overall Performance

Followup on OIG Reports

The Division is responsible for obtaining implementation actions on previously issued audits, inspections, and reviews with over $1.018 billion of actual or potential monetary benefits as of March 31, 2000. Of this amount $860 million is resolved, but not yet realized as

VA officials have agreed to implement the recommendations, but have not yet done so. In addition, $158 million relates to unresolved reviews awaiting contract resolution by VA contracting officers.

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

As of March 31, 2000, VA had 93 open internal OIG reports with 256 resolved but unimplemented recommendations and 34 unresolved contract review recommendations which are awaiting contracting officer's decisions.

After obtaining information that showed management officials had fully implemented corrective actions, the Division took action to close 56 internal reports and 231 recommendations with a monetary benefit of $248 million.

During this period, 100 percent of followup requests on immediate actions were sent within three months. Also, 100 percent of the initial and the subsequent followup letters were processed in less than 3 months. In both cases, we met the standard.

FOIA, Privacy Act, and Other Disclosure Activities

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

During this reporting period, we processed 186 requests under the Freedom of Information and Privacy Acts and released 230 audit, investigative, and other OIG reports. In one instance we had no records. We totally denied four requests under the appropriate exemptions of the Acts. Information was partially withheld in 120 requests because release would have constituted an unwarranted invasion of personal privacy, interfered with enforcement proceedings, disclosed the identity of confidential sources, disclosed internal Department matters, or was specifically exempted from disclosure by statute.

During this period, five FOIA cases did not receive written responses within 20 working days, as required. There are no cases over 1 year old. The average processing time for workable FOIA requests considered complex was 197 working days; routine cases took 19 working days.

Electronic FOIA activities are reported in the Information Technology Division report, which follows this Division's report.

Review and Impact of Legislation and Regulations

The Division coordinated concurrences on legislative and regulatory proposals from the Congress, OMB, and the Department that relate to VA programs and operations. The OIG commented and made recommendations concerning the impact of the legislation and regulations on economy and efficiency in the administration of programs and operations or the prevention and detection of fraud and abuse. During this period, 53 legislative, 32 regulatory, and 58 administrative proposals were reviewed and commented on, as appropriate.

Status of OIG Reports Unimplemented for Over 3 Years

Management officials are required to provide the OIG with documentation showing the completion of corrective actions on OIG reports, including reporting of collection actions until the amounts due VA are either collected or written off. The OIG followup staff conducts desk reviews of status reports submitted by management officials to assess both the adequacy and timeliness of agreed upon actions and to request periodic updates on an ongoing basis. When a status report adequately documents corrective actions, the followup staff closes the recommendation after coordination with the OIG office that wrote the report. If the actions do not implement the recommendation, the followup staff requests a status update.

The following chart lists by office the total number of unimplemented OIG reports and recommendations. It also provides by office the total number of unimplemented reports and recommendations issued in FY 97 and earlier. We are particularly concerned about any report which has not been fully implemented 3 years after being issued.

	Unimplemented OIG Reports And Recommendations			
VA Office	**Total**		**FY 97 and Earlier**	
	Repts	**Recoms**	**Repts**	**Recoms**
VHA	46	188	4	6
FIN	22	44	1*	1*
VBA	16	34	6	10
HRA	3	3	1	1
P&A	2	11	1	1
I&T	2	5	0	0
Others	2	5	0	0
Total	93	290	13	19

* See Appendix C for this contract review report.

Veterans Health Administration

Unimplemented Recommendations and Status (FY 97 and Earlier Reports)

Report: *VHA Activities for Assuring Quality Care for Veterans in Community Nursing Homes, 4R3-A28-016, 1/11/94.*
Recommendation: VHA develop standardized community nursing homes inspection procedures and criteria for approving homes for participation in the program.
Status: VHA provided a 6-page draft directive for selected field comments in March 2000; however, no planned completion date was provided.
Concern: The OIG is concerned that this report, which dates back to 1994, has not yet been implemented. The final report showed that inspection procedures varied between VAMCs, appropriateness of community nursing homes inspection team makeup could be improved, and annual reinspections should be conducted more

timely. These are still issues which need to be addressed to improve care of veterans.

Report: *Audit of Medical Supplies Acquisition and Distribution Systems, 5R4-E01-085, 7/25/95*
Recommendations: The Under Secretary for Health, in conjunction with the Assistant Secretary for Management, should: (1) formally define the roles of national, regional, and local contracting and buying activities, and (2) plan for the establishment of regional buying groups that serve every medical facility in VA.
Status: For recommendation (1) - VHA indicated the formal definition will be addressed through a change to the VA acquisition regulations by April 30, 2000. For recommendation (2) - VHA indicated regional buying groups have been established and their flexibility in exercising multi-VISN contracts will directly relate to the final results of discussions with A&MM on contracting officer certification with an anticipated resolution in March 2000.
Concern: The OIG is concerned that VA has not yet formally defined the roles of each acquisition level (national, regional, and local) so that they can work in partnership to achieve the best results for VA as a whole. In addition, every VA medical facility needs to have access to some form of a regional group buying activity so that purchases from national contracts can be consolidated. We hope these recommendations from this 1995 report will be implemented soon.

Report: *Evaluation of VHA's Policies and Practices for Managing Violent and Potentially Violent Psychiatric Patients, 6HI-A28-038, 3/28/96*
Recommendation: VHA managers should explore network flagging systems that would ensure employees at all VAMCs are alerted when patients with histories of violence present for treatment to their medical centers.
Status: VHA provided a 2-page draft directive on transmission of information on assaultive patients in March 2000, but provided no planned completion date.
Concern: The OIG report included recommendations that were meant to strengthen areas that may reduce that incidence of injury associated with violence in inpatient psychiatric units. The original planned completion date was October 1996. A directive provided in 1998 did not address the issue. The OIG is concerned that very little progress has been made in implementing this recommendation, which dates from 1996, while incidents of patient violence against staff and other patients continue.

Report: *Internal Controls Over the Fee-Basis Program, 7R3-A05-099, 6/20/97*
Recommendations: VHA improve the cost effectiveness of home health services by: (1) establishing guidelines for contracting for such services, and (2) providing contracting officers with benchmark rates for determining the reasonableness of charges.
Status: For recommendation (1) - guidelines are under development in four areas with various target dates, and for recommendation (2) - VHA will update its plan in June 2000.
Concern: The June 1997 final report showed that contracting for home health services could save at least $1.8 million annually, however the recommendations remain unimplemented. The May 1997, comments to the draft report referred to a pilot project that would implement the recommendations. However, 1½ years later, the December 1998, status update reported that the pilot did not address these recommendations. We are concerned that the last three status updates from the program office provided delays in various planned completion dates or dates for when the plan itself would be updated. As a result, over $5.3 million has been spent on these contracts which could have been avoided. We are also concerned that until this condition is corrected, at least $1.8 million annually is not saved.

Veterans Benefits Administration

Unimplemented Recommendations and Status (FY 97 and Earlier Reports)

Report: *Audit of the Effectiveness of Benefit Award Notification, 6D2-B01-049, 6/14/96*
Recommendation: VBA enhance the effectiveness and efficiency of benefit award notification for beneficiaries by accepting oral information (including telephonic input to VA 800 numbers) from primary verified sources when documentary evidence is not required. This would include acceptance of challenges to proposed award actions that would allow a continuation of the suspension of changes that are to be implemented.
Status: In December 1998, VBA stated their intent to draft a regulation to accept information orally. However, in November 1999, VBA stated they were unable to finalize the draft regulation due to staffing changes and stated the draft would be completed by May 2000.
Concern: The audit found opportunities to streamline due process notice and response procedures. The OIG is concerned that very little progress has been made in implementing our recommendation, which dates to 1996, in the ensuing 4 years. Recent conversations with VBA, however, indicate that some procedures do not require regulation changes, but instead revisions will be made to the Adjudication Procedural manual M21-1. We are hopeful that this will be responsive to the recommendation and permit closure of the report in the near future.

Report: *Review of the Causes of VBA's Compensation and Pension (C&P) Overpayments, 7R1-B01-105, 12/2/96*
Recommendation: VBA reduce C&P benefit payments by revising due process procedures to remove the requirement that beneficiaries must inform the VA in writing of status changes that will result in a reduction of benefits.
Status: In November 1999, VBA stated they have been unable to finalize the draft change to the pertinent regulations due to staffing changes, and the draft regulation to revise the due process procedures would be completed by March 2000.
Concern: The audit indicated that C&P overpayments could be reduced $4 million annually, if actions were taken to simplify communications with beneficiaries regarding their responsibility to timely report beneficiary status changes. We are concerned that very little progress has been made in implementing this recommendation during the past 3 years. As a result, approximately $12 million has been spent on C&P overpayments which could have been avoided.

Report: *Appointment and Supervision of Fiduciaries, 7R5-B13-074, 5/1/97*
Recommendations: (1) VBA require fiduciaries to submit financial information release forms authorizing VA to independently verify reported account balances when they submit periodic accountings. (2) Independently verify the balances in selected asset accounts reported by fiduciaries on periodic accountings. (3) Require regional office personnel to routinely review canceled checks or the documentation of selected expenditures reported by fiduciaries. (4) Assess the feasibility and cost-effectiveness of automating the analysis of accountings submitted by fiduciaries.
Status: For recommendation (1), the October 1999 status report stated the VBA staff forwarded the form to the Directives, Forms and Publications staff for review, concurrence, printing, and distribution, and stated the planned completion date was May 2000. For both recommendations (2) and (3), the October 1999 VBA status report stated a circular was drafted and was in the concurrence process, a cost analysis was done and the results of the cost study was being analyzed, and contingent on

favorable results and appropriate budget action, implementation of the circular will begin by June 2000. Full implementation of recommendations 2 and 3 will occur simultaneously. For recommendation (4), the October 1999 status report stated a cost benefit analysis would be completed by December 1999 and a report submitted to VBA management by April 2000.

Concern: In summary, the audit's purpose was to determine if VBA protected the incomes and estates of incompetent beneficiaries ($1.4 billion of funds for 110,000 incompetent beneficiaries). The report found that VBA needs to strengthen monitoring of fiduciaries, in order to protect incomes and estates of incompetent beneficiaries. We are concerned about the 3 year delay in implementation of these recommendations, because of their impact on beneficiaries who cannot protect themselves. However, recent discussions between IG and VBA indicate a different approach will now be taken to simplify the process from a customer viewpoint. Any further delay will continue to affect one of our most vulnerable groups of beneficiaries.

Report: *Review of VBA's Procedures to Prevent Dual Compensation, 7R1-B01-089, 5/15/97*

Recommendation: VBA followup on FYs 1993 through 1996 dual compensation cases to ensure either VBA disability payments are offset or the Department of Defense is informed of the need to offset reservist pay.

Status: The March 2000 status report stated VBA found a number of problems with the data files received from the Defense Manpower Data Center. In March 2000, the Center ran another FY 1999 file and transmitted it to the Hines Benefits Delivery Center. VBA plans to use the data and conduct a test at one station in April 2000. Upon completion of the test, a determination will be made about proceeding further with FY 1993 – 1998 cases. At that time, VBA will also be able to provide a planned completion date.

Concern: The audit's purpose was to determine if VBA's procedures ensured that disability compensation benefits of active military reservists were properly offset from their training and drill pay. It found that 90 percent of the potential dual compensation cases reviewed had not had offsets from their military reserve pay. We are concerned that an estimated $8 million in annual dual compensation payments continue to be made each year because this recommendation has not been implemented.

Report: *Review of C&P Medical Examination Services, 7R1-A02-114, 8/6/97*

Recommendation: VBA establish performance measures for their field facilities, with the objective of improving the rate of incomplete examinations.

Status: The March 1999 VBA status report stated that historically, there has been little systematic collection of data as to the reasons veterans have failed to report for exams. Accordingly, VBA has insufficient data to support the establishment of performance standards. VBA is now gathering information, which may lead to improvement and if appropriate, to the establishment of performance standards. In January 1999, under the joint disability examination steering committee, VBA and VHA established a work group with a goal of significantly reducing the number of incomplete exams. The work group was asked to analyze the reasons for the high rate of incomplete exams and to offer recommendations for reduction. An action plan for the study would be presented at the meeting of the VBA/VHA cross cutting issues committee which was scheduled to be held in April 1999, with a timeline of 90 days to complete the study and to provide final recommendations. VBA indicated additional time beyond the 90 days may be granted if necessary to complete the study. VBA stated additional data was being collected in conjunction with the contract

disability examination pilot project, which commenced in May 1998. Under this project, VBA began collecting data regarding the types of exams that were returned incomplete for both the contractor and a control group of exams requested from VHA medical facilities. There would be insufficient data to begin an analysis until the pilot was concluded at the end of April 1999. VBA is evaluating their procedures and work group recommendations to determine the most efficient and effective way to meet the objective of improving the rate of incomplete exams.

Concern: The audit noted no performance measures exist to prevent or reduce the percent of incomplete medical exams. VBA's view is that the majority of action related to improving the rate of incomplete exams resides with VHA; nevertheless, VBA is assessing the work group's recommendations to determine what organizational measures may be possible to reach this mutual goal. While VBA has worked cooperatively with VHA on this matter, and is continuing to discuss with VHA an approach to meeting this objective, the fact is that it still remains unimplemented.

Report: *Completeness of Data in the VBA's Fiduciary Beneficiary System (FBS), 7R5-B13-129, 9/15/97*

Recommendations: (1) VBA review the pertinent records of all adult helpless children who do not have records in the FBS and take corrective action as appropriate, and (2) periodically compare data in the FBS and the C&P system to identify incompetent beneficiaries who have no records in the FBS and establish FBS records as appropriate.

Status: For recommendation (1), the October 1999 VBA status report stated (i) the computer matches are complete and output documents were delivered to C&P Service in August 1999, (ii) assignment of the work to field stations is under review, (iii) the computer match generated 34,000 records requiring a range of work from record notations to rating action and field examination activity, and (iv) they are studying the impact of the project on overall claims processing to develop a timetable for full implementation of the recommendation, with a planned implementation by September 2000. For recommendation (2), VBA will schedule subsequent reviews and anticipates competing work by September 2001.

Concern: The audit assessed the completeness of data in the FBS and found VBA needed to establish FBS records for about 1,500 beneficiaries. The FBS should include records for all incompetent beneficiaries whose financial affairs must be monitored by VBA. VBA indicated 4,000 records require possible review. We recognize that field station workload considerations impact the implementation of this recommendation. However, OIG is concerned that the recommendations remain unimplemented.

Office of Human Resources and Administration

Unimplemented Recommendation and Status (FY 97)

Report: *Audit of VAMC Use of Intergovernmental Personnel Act Assignments (IPA), 7R8-A19-044, 2/27/97*

Recommendation: Issue detailed guidance on the use of IPAs with emphasis on the issues identified by this audit.

Status: In December 1999, the OIG received a draft copy of a directive and handbook.

Concern: The audit addressed IPAs that are used to facilitate Federal-state-local cooperation through the temporary assignment of skilled personnel. The better use of funds savings was $1.3 million to restrict the use of IPAs to their traditional purpose. VHA has made extensive use of IPAs, primarily for assigning medical

school employees to work on research projects. In FY 96, VAMCs had more than 1,000 IPAs with costs of at least $35 million. The audit noted IPAs were inappropriately used to obtain clinical services and for administrative and support positions. The original planned completion date to revise the policy was April 1997. VHA, with the assistance of the Office of Human Resources and Administration, issued two memoranda (in 1996 and 1997) instructing facility directors on the proper use of IPAs at medical centers. In addition, the Office of Personnel Management issued changes to regulations pertaining to IPAs on April 29, 1997. Changes included a new requirement that organizations not covered by provisions of Executive Order 11589 were to be certified by Federal agencies. In response to this new requirement, VA policy was issued in 1999 to incorporate the new requirements and provide facilities needed information to use IPAs properly. The Office of Human Resources and Administration has assured the OIG that the final directive and handbook will be issued by June 30, 2000.

Office of Planning and Analysis

Unimplemented Recommendation and Status (FY 95 Report)

Report: *Audit of the General Post Fund (GPF), 5R7-A16-033, 2/10/95*
Recommendation: Take steps necessary to finalize the revised policy to implement Public Law 102-86 that broadened VA's authority to accept and use gifts. The revised policy should ensure that the GPF is expended for purposes that directly benefit veterans.
Status: In July 1998, the OIG concurred with an Office of Planning and Analysis delegation package that included a proposed memo from the Secretary that would delegate to Administrative Heads Assistant Secretaries, and other key officials the Secretary's authority to accept gifts and to communicate the delegation throughout VA. The package stated it was expected that gifts would be increased with the delegation. The package went to the Secretary's mail call in August 1998. It is still in the Executive Secretariat's office per the latest status update from the Office of Planning and Analysis.
Concern: The GPF is a trust fund that consists of donations for assisting veterans and for designated research. The VA GPF fund balance was $70 million in September 1994. Public Law 102-86 broadened the acceptance and use of the GPF, and VA is no longer limited to accepting and using GPF for veterans in VA medical facilities. However, VA has not established policy to implement the Public Law passed in 1991 and consequently VA's authority to provide additional assistance and services provided by the legislation has not been used. No planned completion date is available.

III. INFORMATION TECHNOLOGY DIVISION

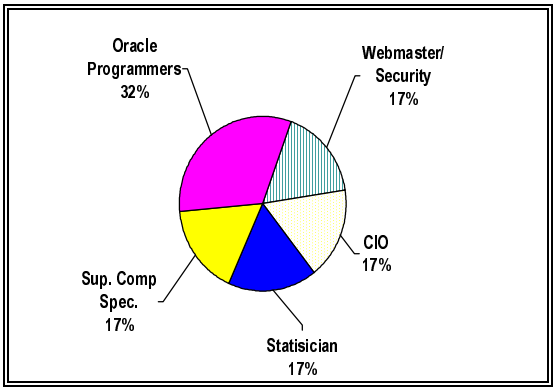
Mission Statement

Promote OIG organizational effectiveness and efficiency by ensuring the accessibility, usability, and security of OIG information assets; developing, maintaining, and enhancing the enterprise database application; facilitating reliable, secure, responsive, and cost-effective access to this database, VA databases, and electronic mail by all authorized OIG employees; providing Internet document management and control; and providing statistical consultation and support to all OIG components.

The Information Technology Division provides information technology and statistical support services to all components of the OIG. It has responsibility for the continued development and operation of the management information system, as well as the OIG's Internet resources. The Division interfaces with VA information technology units nationwide to establish and support local and wide area networks, guarantee uninterrupted access to electronic mail, service personal computers, detect and defeat computer threats, and provide support in protecting all electronic communications. The Division, which is managed by the OIG's Chief Information Officer (CIO), represents the OIG on numerous intra- and inter-agency organizations and is responsible for strategic planning for all OIG information technology requirements. Finally, a member of this division serves as the OIG statistician.

Resources

The Division has 6 FTE currently assigned to the OIG headquarters and allocated to the following areas:



Overall Performance

Master Case Index (MCI)

On October 4, 1999, the OIG completed the initial implementation of an Oracle database application known as the Master Case Index (MCI) to replace a non-Y2K compliant nine-year old legacy Oracle application. This implementation resulted in a new case numbering format, on-line search tools, and an index to external reports of interest to the OIG. The graphical user interface of MCI has provided users with intuitive access to their data denied them in the legacy application, which required experienced programmers to conduct on-line queries. Additionally, users now have appropriate access to enterprise-wide data instead of only data pertaining to their operational directorate.

During the last 6-months, we completed on-site, instructor-led MCI training in ten cities. Consequently, we have expanded the user base from approximately 40 in the legacy application to nearly all OIG employees. Data validation tables, picklists, and search tools have resulted

in increased accuracy and non-duplication of data entered into our enterprise database.

We have also completed more than 150 enhancements, ranging from cosmetic to very significant, since initial implementation. As a result of an increased user base, we have identified approximately 60 additional enhancements that we plan to implement during the next six months. We encountered two Oracle induced Y2K problems within MCI; both were quickly corrected without impact on our users.

Internet Technology/Security

The Division is responsible for processing and controlling electronic publication of OIG reports, including maintaining the OIG websites and posting OIG reports on the Internet. The OIG public website received over 2,500,000 hits from over 140,000 visitors which ranked it on average among the top five accessed directories on the VA's website. Our most popular reports were downloaded over 21,000 times, providing both timely access to our customers and cost avoidance in the reduced number of reports that must be printed and mailed.

We posted frequently-requested CAP, administrative investigation, and audit reports in our electronic reading room in compliance with the Electronic Freedom of Information Act. We published 12 additional audit reports, 47 Office of Investigations press releases, and other OIG publications online.

We coordinated the electronic notification to top VA managers of an OIG report on high-risk areas in VHA's Workers' Compensation Program. On our website, we posted privacy notices at all major information collection points and further enhanced accessibility for disabled customers.

We participated in departmental efforts in improving information security and availability including recent budgetary and policy initiatives. Our involvement included reviews of the Department's information security policies and initiatives, input on the Department's public key infrastructure encryption efforts, and participation in Department efforts to improve VA web site accessibility.

Statistical Support

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

In the past reporting period, the OIG statistician provided statistical consultation and support on 13 sampling plans for proposed audit projects. These plans were reviewed for completeness and accuracy in the proposed samples in order to arrive at defensible projections back to the universe of the audit. Similarly, the OIG statistician also provided statistical support and consultation on the OHI proactive program evaluations examining VHA's policies and search procedures related to missing patients. The statistician was responsible for developing the sampling strategy and plan for the evaluation, as well as providing statistical support in analyzing preliminary data.

For the recently ended reporting period, the OIG statistician provided consultation and support on all CAPs. This support involved preparing and processing the random samples of full-time VAMC employees who were part of the CAP's employee satisfaction survey. In addition, the statistician provided support in the processing of the CAP's data collected while on-site and

provided consultation on the accurate interpretation and appropriate presentation of the data findings in the CAP reports. The statistician also provided statistical supporting data on two Hotline cases investigated by the OHI.

Finally, the statistical expertise of the OIG statistician was called upon by other VA administrations within the Department in the past reporting period. The statistician was asked to review and comment on the proposed sampling plan for the Department's FY 2000 national survey of veterans. The statistician also participated in the departmental working group reviewing appropriate data sources for use in the development of the new veterans' population model.

Information Technology Training Initiative

OIG management has recognized the necessity to develop and implement an ADP training program for all OIG employees. This division conducted a survey of all employees, which established each employee's current and desired levels of expertise in using the following Microsoft software packages: *Word, Excel, PowerPoint, Access, Outlook, Project, Windows 95,* and *Windows NT 4.0.*

The objectives of the questionnaire were to: establish a portfolio of PC software competencies within the OIG; gauge the demand for specific courses of instruction; identify the most efficient, cost-effective means of delivering this instruction tailored to each individual's needs; and create a baseline for measuring the effectiveness of different types of software instruction

The survey's 97 percent response rate confirmed the intense desire for training with over 1,900 specific requests for user training on the software packages listed above.

We evaluated a number of computer based training packages and selected one initially developed for the IRS. This multimedia computer-based training contains tutorials for novice, intermediate, and advanced users of the above software packages. Since this tutorial was developed for the Federal Government, we will be able to procure a compact disk set for each employee at nominal cost. We also plan to select a vendor capable of providing instructor-led training in each city in which we have employees assigned.

IV. RESOURCES MANAGEMENT DIVISION

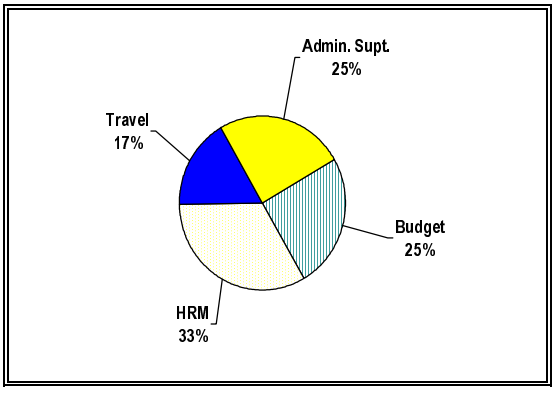
Mission Statement

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

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

Resources

The Division has 12 FTE currently assigned to the OIG headquarters. The staff allocation for the four functional areas is as follows:



Overall Performance

Budget

The staff assisted in the preparation of the FY 2001 budget submission and materials for associated hearings in the Department and with the Office of Management and Budget and Congressional Committees.

The staff executed 45.4 percent of the OIG's FY 2000 budget authority.

Human Resources Management

During this period, the staff brought 7 new employees on board. In addition, the staff processed 153 personnel actions, 1 distinguished career award, 4 outstanding career awards, 48 special contribution awards, 12 time-off awards, and 1 on-the-spot award.

Travel

OIG personnel travel almost continuously. As a result, the Travel section processed 1,493 travel and 75 permanent change of station vouchers in addition to 4 new permanent change of station authorities and 35 amendments to existing authorities.

Administrative Support

Several relocation projects were completed during this period. These projects involved substantial planning and coordination between OIG staff and various outside parties to ensure a smooth transition and minimal impact on work processes. The administrative staff works closely with building management to coordinate office renovation plans, telephone installation, and the procurement of furniture and equipment.

In addition, this component processed 278 procurement actions and reviewed and approved each month the 42 statements received from the OIG's cardholders under the Government's purchase card program.

OTHER SIGNIFICANT OIG ACTIVITIES

President's Council on Integrity and Efficiency (PCIE)

Members of the Financial Audit Division participate as members of the PCIE Federal Audit Executive Committee (FAEC) subgroup. The purpose of the subgroup is to: (i) keep members current on changes in Federal financial statement auditing requirements; (ii) allow members to exchange ideas and advice to assist in accomplishing their agency's audits; (iii) raise issues of mutual concern to the PCIE; and (iv) present a forum for the members to express their concerns or solicit advice and guidance from representatives of the Office of Management and Budget and the General Accounting Office.

OIG Management Presentations

Presentation to Leadership VA 1999

The Inspector General made a presentation on the work of the OIG to the Leadership VA class of 1999. This program is VA's premier leadership development program.

Presentation at VBA's Training Academy

Two audit Directors (Management Audit Division and Atlanta Operations Division) and the investigations Director of the Benefits Fraud Division briefed VBA's program integrity teams on vulnerabilities in the compensation and pension programs.

Association of Military Surgeons of the United States, Society of Federal Agencies Conference

The association was incorporated by act of Congress in 1903, with members from the Medical Departments, U.S. Public Health Service, and VA. OHI managers and health systems specialists presented research posters at the 106th annual meeting. Presentations were made on three OHI evaluations.

VHA's Center for Patient Safety Pilot Root-Cause Analysis

The AIG for Healthcare Inspections served as a faculty member for the VHA root-cause analysis training. Root-cause analysis is a form of quality management focused review that, when fully implemented by VHA, will supplant the current system that VHA uses for evaluating events that result in serious patient injuries (sentinel events).

2000 VHA Pharmacy Conference

OHI's Los Angeles Team Leader, a trustee on the Board of the American Pharmaceutical Association, gave a presentation on the OIG and the CAP, at the conference.

5th Annual Veterans Affairs Physician Assistant Association Conference

An OHI staff member gave an overview presentation of the OIG at the annual conference.

VISN 22 Executive Leadership Council

The OHI Los Angeles Region Director gave a presentation on the OIG and the CAP during the conference.

Federal Women's Program

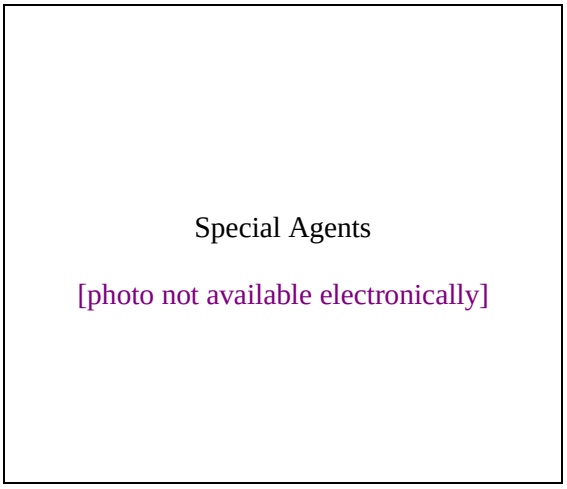
OHI's Midwest Region Director, an OIG representative on VA's Federal Women's Program, was the keynote speaker at the Dorn VAMC, Columbia, SC and the VAMC Walla Walla, WA for Women's History Month. Her presentation was entitled *"The Role of Federal Women for the New Millennium."*

Awards

Columbia University Nursing Hall of Fame

Irene Trowell-Harris, Ed.D., R.N., OHI Midwest Region Director, was inducted into the Columbia University Teachers College Nursing Hall of Fame, for her distinguished nursing leadership and outstanding contribution to the advancement of the profession.

U.S. Attorney Award



Special Agent Sean Smith, Special Agent Lisa Mantione, and Investigative Assistant Connie Meyer were given an award by the U. S. Attorney's office of the Southern District of Florida for a VA OIG equity skimming investigation.

OIG Congressional Testimony

In March 2000, the Assistant Inspector General for Auditing and the Directors, Financial Statement Audit Division and Bedford Audit Operations Division, testified before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations. The testimony addressed the OIG's views on VBA's loan guaranty housing credit assistance program accounting, and summaries of audits and investigations of the loan guaranty program.

Obtaining Required Information or Assistance

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

Under P.L. 95-452, the IG has authority "… to require by subpoena the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence necessary . . . ." The use of IG subpoena authority has proven valuable in our efforts, especially in cases dealing with third parties. During this reporting period, 25 subpoenas were issued in conjunction with various OIG investigations and audits.

APPENDIX A

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM				
99-00695-8 10/28/99	Combined Assessment Program Review Department of Veterans Affairs Medical Center St. Louis, MO			$10,176
99-00173-18 11/22/99	Combined Assessment Program Review Edward Hines, Jr. VA Hospital Hines, IL			
99-00161-24 12/30/99	Combined Assessment Program Review VAMC Philadelphia, PA			
00-00358-44 3/20/00	Combined Assessment Program Review, Carl Vinson VA Medical Center Dublin, GA			
INTERNAL AUDITS				
98-00057-1 10/1/99	Audit of Procurement Initiatives for VA's Integrated Data Communications Utility (IDCU) Telecommunications Support	$146,129,631	$146,129,631	$1,025,660
99-00188-13 11/15/99	Audit of Management of Prosthetic Supply Inventories at VA Medical Centers and the Denver Distribution Center	$31,428,000	$31,428,000	
99-00046-16 12/21/99	Audit of High-Risk Areas in the Veterans Health Administration's (VHA) Workers' Compensation Program (WCP)	$11,200,000	$11,200,000	
99-00055-12 1/7/00	Audit of Allegations Concerning the VA Office of Congressional Affairs (OCA)			
98-00156-39 2/9/00	Audit of Advanced Food Processing and Delivery Systems In Ohio and Western Pennsylvania			
99-00006-46 3/14/00	Report of Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 1999 and 1998			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
INTERNAL AUDITS (Cont'd)				
99-00055-47 3/22/00	Addendum Report: Audit of Allegations Concerning the VA Office of Congressional Affairs			
99-00180-52 3/31/00	Audit of Fee Basis Claim Payments Northern California Health Care System, Martinez, CA			
OTHER OFFICE OF AUDIT REVIEWS				
98-00009-2 10/1/99	Management Letter – Fund Balance with Treasury, Agency Location Code 36-00-1200			
99-00011-3 10/1/99	Administrative Investigation, Use of Travel, Representation Funds, and Motor Vehicles with Respect to the Secretary of Veterans Affairs			$375
99-00187-9 10/26/99	Evaluation of VA Medical Center Management of Prosthetics and Sensory Aids Procurement			
99-00008-25 12/22/99	Report on Agreed to Procedures			
99-00003-33 1/20/00	Management Letter - VA's Minimum Password Configuration Policy			
00-00983-41 2/23/00	Attestation of the Department of Veterans Affairs "Detailed Accounting Submission" for Fiscal Year 2000			
99-00159-42 2/28/00	Evaluation of Loan Guaranty Service's Quality Review System			
99-00046-48 3/24/00	Management Advisory Letter - Workers' Compensation Program Assist, Veterans Integrated Service Network (VISN) 5			
CONTRACT REVIEWS *				
99-00144-5 11/4/99	Audit of VA Payments and Funding Issues on a Major Construction Contract (Number V101cc0098) for the Clinical and Outpatient Addition at VA Medical Center Marion, IL			$265,792
99-00141-11 11/8/99	Review of Ambulance Service Proposal (Solicitation Number RFP 652-5-00) Richmond Ambulance Authority, Richmond, VA	$117,000		

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
98-00120-15 11/9/99	Postaward Review of Federal Supply Schedule Contract V797P-5538m, Awarded to UCB Pharma, Inc.			$68,434
99-00143-17 11/10/99	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97 OSI) Ortho-McNeil Pharmaceutical, Inc., Raritan, NJ	$18,747,758		
99-00083-20 12/7/99	Review of Roxane Laboratories, Inc. Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Numbers V797P-5501m and V797P-5348x			$1,641,371
00-00302-23 12/22/99	Review of Federal Supply Schedule Proposal (Solicitation Number 797-652B-99-0003), Coloplast, Inc., Marietta, GA			
99-00084-27 12/29/99	Review of Watson Laboratories, Inc. Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Numbers V797P-5260n and V797P-5339x			$34,018
00-00266-30 1/14/00	Review of Proposal for Cardiac Surgery Services at University Drive Division, VA Pittsburgh Healthcare System Submitted by University of Pittsburgh Physicians, Pittsburgh, PA	$334,945		
99-00073-34 1/20/00	Survey of B. Braun Medical, Inc.'s Public Law 102-585, Section 603 Policies and Procedures			$41,993
00-00970-38 2/3/00	Final Report – Review of J. T. Posey Company's Voluntary Disclosures Under Federal Supply Schedule Contract Numbers V797P-3953j and V797P-3563k			$1,780
00-00795-40 2/8/00	Review of Alternate Federal Supply Schedule Pricing Proposal (Solicitation Number M6-Q5-98) Circon Acmi, Stamford, CT	$1,006,434		
97-00111-22 2/9/00	Report of Postaward Review of Federal Supply Schedule Contract V797P-3668j, Awarded to Stryker Corporation			$495,550
99-00058-35 2/10/00	Final Report Review of Riverside National Cemetery's Contracting Practices Relating to Grave Liners and Grave Markers			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
00-00267-45 3/2/00	Review of Federal Supply Schedule Proposal (Solicitation Number 797-652F-99-0004) Crown Therapeutics Inc., Belleville, IL	$779,335		
98-00086-49 3/21/00	Review of Voluntary Disclosure and Refund Offer on Federal Supply Schedule Contract No. V797P-5636n Submitted by NABI, Rockville, MD			$221,749
00-01052-51 3/27/00	Review of Scarce Medical Specialists' Proposal for Surgical Services (Solicitation Number RFP 509-16-99) Submitted by Medical College of Georgia, Augusta, GA			
ADMINISTRATIVE INVESTIGATIONS				
99-01779-21 12/9/99	Administrative Investigation, Misconduct and Other Issues, VA Heartland Network, Kansas City, MO			
99-01785-14 12/21/99	Administrative Investigation, Conduct, Attendance, and Travel Issues, Veterans Benefits Administration Regional Office Portland, OR			$20,285
00-00778-26 12/29/99	Administrative Investigation, Misuse of a Government Vehicle, Central Alabama Veterans Health Care System			
97-00957-29 1/19/00	Administrative Investigation, Use of Government Resources and Other Issues, Great Lakes Healthcare System, Hines, IL			$1,035
99-01789-28 1/25/00	Administrative Investigation, Personnel Practices, Central Texas Veterans Health Care System			$672
99-01781-32 2/25/00	Administrative Investigation, Use of Frequent Flyer Mileage Points and Other Travel Issues, VAMC Long Beach, CA			$5,767
99-01783-43 2/29/00	Administrative Investigation, Use of Government Resources, Conduct, and Travel Issues, Connecticut Health Care System and Central Plains Veterans Integrated Service Network			$1,857
99-01792-31 3/23/00	Administrative Investigation, Vocational Rehabilitation Work Therapy Programs Issues, VAMC Northport, NY			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
HEALTHCARE INSPECTIONS				
97-00680-6 10/7/99	Alleged Research Improprieties and Informed Consent Issues, Jerry L. Pettis Memorial Veterans Hospital, Loma Linda, CA			
99-00764-4 10/15/99	Evaluation of the Department of Veterans Affairs Veterans Health Administration Hepatitis C Initiative			
98-00501-7 10/28/99	Inspection of Alleged Substandard Patient Care, Department of Veterans Affairs Medical Center Miami, FL			
98-00600-10 11/4/99	Inspection of Alleged Inadequate Trauma Treatment, James A. Haley Veterans Hospital Tampa, FL			
99-00623-19 1/20/00	Inspection of Allegedly Unexpected Patient Deaths and Review of Domiciliary Operations, Department of Veterans Affairs Medical Center Biloxi, MS			
99-00859-36 2/22/00	Inspection of Alleged Inappropriate Plastic Surgery, Department of Veterans Affairs Medical Center Washington, DC			
TOTAL:	**50 Reports**	**$209,743,103**	**$188,757,631**	**$3,836,514**

APPENDIX B

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

Report Title (Report Number, Issue Date)	Funds Recommended for Better Use	Unsupported Costs
Costs Incurred, Direct and Indirect, Fiscal Year Ended 9/30/96 and 9/30/97, Mitretek System, Inc., McLean, VA (1998-02760-PE-0133-N03, 10/26/99)		
Claim, Contracting No. V101cc-0052, Construction, VAMC Detroit, Centex Construction Company, Dallas, TX (1999-03107-PE-0107-N02, 10/26/99)	$36,947,663	
Proposal, Project No. 693-026, Ambulatory Care Addition, VAMC Wilkes-Barre, Bell Constructor Inc., Rochester, NY (1998-02710-PE-0010-N02, 10/28/99)		
Proposal, RFP No. 600-145-98cw, Urology Services, VAHS Long Beach, University of California, Irvine, Irvine, CA (1999-00059-PE-0006-N03, 12/13/99)	$697,613	
Proposal, RFP No. 652-159-99, Corridor Remodeling, VAMC Richmond, Metrotec Associates, Inc., Virginia Beach, VA (1999-03293-PE-0113-N03, 12/15/99)	$9,159	
Claim, Project No. 317-007, Construction, VARO St. Petersburg, J. Kokolakis Contracting, Inc., Tarpon Springs, FL (1999-03115-PE-0201-N02, 12/22/99)	$2,866,738	
Claim, Project No. 508-018c, Clinical Addition, VAMC Atlanta, Caddell Construction Co., Montgomery, AL (1999-03095-PE-0001-N02, 12/29/99)		
Proposal, Project No. 920-001 A/E, VANC Fort Sill, Poe & Associates Oklahoma City, OK (2000-00021-PE-0201-N02, 2/29/00)		
Claim, Contract No. V101AC0141, Construction VAMC Mountain Home, TN, Summit Construction Co., Inc., Cuyahoea Falls, OH (2000-00021-PE-0002-N02, 3/21/00)	$149,760	
TOTALS: 9 Reports	**$42,858,727**	**$0**

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

APPENDIX C

CONTRACT REVIEW REPORTS FOR WHICH A CONTRACTING OFFICER DECISION HAD NOT BEEN MADE FOR OVER 6 MONTHS AS OF MARCH 31, 2000

Report Title, Number, and Issue Date	Questioned Costs	Recommended Better Use of Funds	Reason for Delay and Planned Date for a Decision
Contract Reviews by OIG			
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT			
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97), Wyeth-Ayerst Laboratories, Philadelphia, PA, 7PE-E02-127, 9/4/97		$5,484,450	Pending receipt of Contracting Officer Price Negotiation Memorandum (PNM); anticipated award date is May 31, 2000.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Boehringer Ingelheim Pharmaceuticals, Inc., Ridgefield, CT, 8PE-E02-021, 10/16/97		$7,893,240	Pending receipt of Contracting Officer PNM; anticipated award date is May 31, 2000.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q4-97), Medrad, Inc, Indianola, PA, 8PE-E02-084, 3/19/98		$2,468,847	Pending receipt of Contracting Officer PNM; anticipated award date is June 30, 2000.
Audit of Claims and Requests for Equitable Adjustments Submitted by Bay Construction Company, Contract Number V662C-1439, 8PE-E10-082, 3/25/98		$394,154	Claim in litigation; no planned resolution date available.
Audit of Claim for Alleged Damages Under an Agreement with a VAMC, 8PE-A12-104, 7/1/98		$318,008	Claim in litigation; no planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q4-97), Imation Enterprises Corporation Oakdale, MN, 8PE-E02-108, 7/20/98		$165,779	Pending receipt of Contracting Officer PNM; anticipated award date is June 30, 2000.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q4-97) Eastman Kodak Company, Rochester, NY, 9PE-X04-004, 11/30/98		$17,989,200	Pending receipt of Contracting Officer PNM; no planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Baxter Healthcare Corporation, Deerfield, IL, 9PE-X01-022, 2/4/99		$2,409,502	Pending receipt of Contracting Officer PNM; anticipated award date is May 31, 2000.

Report Title, Number, and Issue Date	Questioned Costs	Recommended Better Use of Funds	Reason for Delay and Planned Date for a Decision
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT (Cont'd)			
Review of Federal Supply Schedule Proposal (Solicitation Number M3-QF-98) Everest & Jennings, Earth City, MO, 9PE-E02-036, 2/23/99		$680,400	Pending receipt of Contracting Officer PNM; anticipated award date is May 31, 2000.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Baxter Healthcare Corporation – Hyland Division, Deerfield, IL, 9PE-X01-139, 8/6/99		$1,127,908	Pending receipt of Contracting Officer PNM; no planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q2B-98) Phoenix Medical Technology, Inc., Andrews, SC, 9PE-X05-135, 8/20/99		$107,534	Pending receipt of Contracting Officer PNM; no planned decision date available.
Contract Reviews by Other Agencies			
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT			
Claim, Contract V101DC-0048, Expand/Renovate Bldg-1, VAMC Salt Lake, Interwest Construction Salt Lake City, UT, 7PE-N03-114, 9/30/97	$1,469,934		Claim in litigation; planned resolution date not available.
Claim, Contract No. V621C-505, Correct Lake Drainage, VAMC Mountain Home, TN, Carpenter Construction, Inc., Robbinsville, NC, 9PE-N03-107, 5/12/99	$300,626		Claim in litigation; no planned resolution date available.
Proposal, Project No. 543-015, Sprinkler & Fire Alarm Pro., VAMC Columbia, SC, Fire Security System, Inc., Bossier City, LA, 9PE-N03-108, 7/27/99	$1,109,745		Claim in litigation; no planned resolution date available.
Claim, Contract No. V640P-5285, Transportation Services, VA HCS Palo Alto, Bay Trans Company, Inc., Santa Clara, CA, 9PE-N03-111, 8/18/99	$1,463,111		Claim in appeal; no planned resolution date available.
OFFICE OF FACILITIES MANAGEMENT (VHA)			
Adjustment Claim, V101C-1606, Construction Service, VAMC Albany, Bhandari Constructors Inc., Syracuse, NY, 5PE-N02-007, 3/31/95	$271,599		Negotiation not finalized; planned resolution by June 30, 2000.
Claim, Contract No. V101C-1651, Environment Improvement, VAMC North Chicago, Blount Inc. 4PE-N02-202, 2/7/96	$7,370,861		Negotiation not finalized; planned resolution by June 30, 2000.

Report Title, Number, and Issue Date	Recommended Better Use of Funds	Unsupported Costs	Reason for Delay and Planned Date for a Decision
OFFICE OF FACILITIES MANAGEMENT (VHA) (Cont'd)			
Claim, Contract V101C-1532, Asbestos Removal VAMC W. Roxbury, Saturn Construction Co., Inc., Valhalla, NY, 5PE-N02-006, 2/23/96	$875,708	$1,898	Negotiation not finalized; resolution planned for next reporting period.
Claim, Project No. 553-808, Replacement Hospital, VAMC Detroit, MI, Bateson/Dailey, Dallas, TX, 6PE-N02-204, 12/11/96	$11,952,726		Negotiation not finalized; planned resolution by September 30, 2000.
Proposal, Project No. 549-085, Clinical Addition, VAMC Dallas, Centex Construction Company, Inc., Dallas, TX, 7PE-N02-303, 5/20/97	$14,804,392		Negotiation not finalized; planned resolution by November 1, 2000.
Proposal, Project No. 672-045, Change Order Outpatient Clinic Add., VAMC San Juan, J. A. Jones Construction Co., San Juan, PR, 7PE-N02-007, 12/9/97	$284,827		Negotiation not finalized; planned resolution by July 31, 2000.
Claim, Project Nos. 549-085/031 A/E, VAMC Dallas, Dahl Architects, Inc., /F&S Partner, Inc., Dallas, TX, 8PE-N02-110, 10/27/98			Negotiation not finalized; planned resolution by June 30, 2000.
Claim, Project No. 580-040, Electrical, VAMC Houston, TX, Centex Bateson Construction Company, Inc., Dallas, TX, 5PE-N02-307, 2/18/99	$3,280,340		Negotiation not finalized; planned resolution by September 30, 2000.
Claim, Contract No. V101BC131, Ambulatory Care Addition, VAMC San Juan, J. A. Jones Construction Co., Charlotte, NC, 9PE-N02-013, 4/6/99	$3,787,571		Negotiation not finalized; planned resolution date July 31, 2000.
Proposal, Project No. 612-101F, A/E, SMP-SHG, VAOPC Fairfield San Francisco, CA, 9PE-N02-102, 4/21/99	$78,323	$68,334	Negotiation not finalized; planned resolution date November 1, 2000.
Proposal, Project No. 600-401, A/E, VAMC Long Beach, HMC Group, Ontario, CA, 9PE-N02-104, 5/12/99		$1,052,746	Negotiation not finalized; planned resolution date June 15, 2000.
Claim, Project No. 610-090, Construction, VAMC Marion, Caddell Construction Co., Montgomery, AL, 9PE-N02-103, 6/16/99	$122,999		Negotiation not finalized; planned resolution date June 30, 2000.
Proposal, Project No. 614-011, Seismic/Modernization, VAMC Memphis, Caddell Construction, 9PE-N02-007, 9/15/99	$1,912,868		Negotiation not finalized; planned resolution date October 31, 2000.
Claim, Project No. 685-077, Roofing, VAMC WACO, Young Enterprises, Sherman, TX, 9PE-N02-108, 9/15/99	$442,774		Negotiation not finalized; planned resolution date July 15, 2000.

Report Title, Number, and Issue Date	Recommended Better Use of Funds	Unsupported Costs	Reason for Delay and Planned Date for a Decision
OFFICE OF THE GENERAL COUNSEL			
Claim, Project No. 632-062, 120 Bed Nursing Home Care Unit, VAMC Northport, J.F. O'Healy Construction Corporation, Bayport, NY, 3PE-N02-001, 3/26/96	$1,623,126		General Counsel in settlement discussions; no planned resolution date available.
Claim, Contract No. V554C-684, Laundry Chute VAMC Denver, CO, Hughes-Groesch Construction Co., Inc., Denver, CO, 7PE-N03-130, 3/31/97	$450,977		Claim in litigation; planned resolution by December 31, 2000.
Claim, Project No. 690-035 MFI Addition, VAMC Brockton, Saturn Construction Co., Inc., Valhalla NY, 6PE-N02-001, 5/19/97	$724,755		General Counsel in settlement discussions; no planned resolution date available.
Proposal, Project No. 543-015, Sprinkler & Fire Alarm Pro, VAMC Columbia Fire Security Systems, Inc., Bossier City, LA, 8PE-N03-110, 3/19/98	$503,356		Claim in litigation; planned resolution by January 31, 2001.
OFFICE OF GERIATRICS AND EXTENDED CARE (VHA)			
A-128, Fiscal Year Ended 6/30/96, State Approving Agency Contract, State Veterans Home, State of Tennessee, Nashville, TN, 8PE-G06-047, 1/9/98			Negotiation not finalized; planned completion date could not be provided.

APPENDIX D

FOLLOWUP/RESOLUTION OF OIG RECOMMENDATIONS

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

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

SUMMARY OF UNRESOLVED AND RESOLVED OIG AUDITS

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

TABLE 1 - SUMMARY OF UNRESOLVED AUDIT REPORTS

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

MONTHS	TYPE AUDIT	NUMBER	TOTAL
Over 6 Months	Internal Audit	0	34
	Contract Review	34	
Less Than 6 Months	Internal Audit	0	9
	Contract Review	9	
	TOTAL		**43**

Tables 2 and 3 show a total of 40 reports that were unresolved as of March 31, 2000. This number differs from the 43 reports shown above because tables 2 and 3 include only reports with monetary benefits as required by the IG Act Amendments. Tables 2 and 3 also provide the reports resolved during the period with the OIG estimates of disallowed costs and funds to be put to better use, including those in which management agreed to implement OIG recommendations and those in which management did not agree to implement OIG recommendations. The Assistant Secretary for Financial Management maintains data on the agreed upon reports and Management estimates of disallowed costs and funds to be put to better use in order to comply with the reporting requirements for the Secretary's Management Report to Congress, required by the IG Act Amendments.

TABLE 2 - RESOLUTION STATUS OF REPORTS WITH QUESTIONED COSTS

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

RESOLUTION STATUS	NUMBER OF REPORTS	QUESTIONED COSTS (In Millions)
No management decision by 9/30/99	0	$0
Issued during reporting period	16	$3.8
Total Inventory This Period	**16**	**$3.8**
Management decision during reporting period		
Disallowed costs (agreed to by management)	16	$3.8
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Period	**16**	**$3.8**
Total Carried Over to Next Period	**0**	**$0**

Definitions:

- **Questioned Costs**

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

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

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

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

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

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

RESOLUTION STATUS	NUMBER OF REPORTS	RECOMMENDED FUNDS TO BE PUT TO BETTER USE (In Millions)
No management decision by 9/30/99	43	$116.2
Issued during reporting period	14	$252.6
Total Inventory This Period	**57**	**$368.8**
Management decisions during reporting period		
Agreed to by management	10	$198.0
Not agreed to by management	7	$5.7
Total Management Decisions This Period	**17**	**$203.7**
Total Carried Over to Next Period	**40**	**$156.0[1]**

[1] The opening balance ($116.2), plus the reports issued during the period ($252.6), minus the management decisions this period ($203.7), does not equal the closing balance ($156.0) due to a decrease in BUOF during the period amounting to $9.1 million.

Definitions:

- **Recommended Better Use of Funds**

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

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

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

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

APPENDIX E

REPORTING REQUIREMENTS OF THE INSPECTOR GENERAL

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

IG Act References	Reporting Requirement	Page
Section 4 (a) (2)	Review of legislation and regulations	66
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-75
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-75
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	91
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	i
Section 5 (a) (5)	Summary of instances where information was refused	78
Section 5 (a) (6)	List of audit reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use	79-85 (App. A & B)
Section 5 (a) (7)	Summary of each particularly significant report	i to v
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	92 (Table 2)
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	93 (Table 3)
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	87 to 90 (App. C)
Section 5 (a) (11)	Significant revised management decisions	None
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	None
Section 5 (a) (13)	Information described under section 05(b) of the Federal Financial Management Improvement Act of 1996 (Public Law 104-208)	43

APPENDIX F

OIG OPERATIONS PHONE LIST

Investigations

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

Healthcare Inspections

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

OIG OPERATIONS PHONE LIST (CONT'D)

Audit

Central Office Operations Division (52CO) Washington, DC .....(202) 565-4433
Contract Review and Evaluation Division (52C) Washington, DC.....(202) 565-4818
Financial Management Audit Division (52CF) Washington, DC .....(202) 565-7913
Austin Residence (52AU) Austin, TX .....(512) 326-6216
Operations Division Atlanta (52AT) Atlanta, GA .....(404) 929-5921
Operations Division Boston (52BN) Bedford, MA .....(781) 687-3120
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Dallas Residence (52DA) Dallas, TX .....(214) 655-6000
Operations Division Seattle (52SE) Seattle, WA.....(206) 220-6654
Los Angeles Residence (52LA) Los Angeles, CA.....(310) 268-4336

APPENDIX G

GLOSSARY

A&MM	Acquisition and Materiel Management
AFPDS	Advanced Food Processing and Delivery Systems
AIG	Assistant Inspector General
BVA	Board of Veterans Appeals
CAP	Combined Assessment Program
C&P	Compensation & Pension
CFS	Consolidated Financial Statements
DCIS	Defense Criminal Investigative Service
DDC	Denver Distribution Center
DEA	Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
DOL	Department of Labor
FBI	Federal Bureau of Investigation
FBS	Fiduciary Beneficiary System
FDA	Food and Drug Administration
FFMIA	Federal Financial Management Improvement Act
FOIA	Freedom of Information Act
FTE	Full Time Equivalent
FY	Fiscal Year
GPF	General Post Fund
GPRA	Government Performance and Results Act
HCA	Housing Credit Assistance
HCV	Hepatitis C Virus
HHS	Department of Health and Human Services
HUD	Department of Housing and Urban Development
IDCU	Integrated Data Communications Utility
IRS	Internal Revenue Service
IG	Inspector General
IPA	Intergovernmental Personnel Act
LGS	Loan Guaranty Service
MCI	Master Case Index
NCA	National Cemetery Administration
OA&MM	Office of Acquisition and Materiel Management
OCA	Office of Congressional Affairs
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
OMB	Office of Management and Budget
PCIE	President's Council on Integrity and Efficiency
PDAS	Principal Deputy Assistant Secretary
QPA	Quality Program Assistance [Review]
SSA	Social Security Administration
USSS	United States Secret Service
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
Y2K	Year 2000

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

The report is also available on our Web Site:

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

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