Inspection and Evaluation Committee

President's Council on Integrity and Efficiency

December 2007

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For More Information...

For more information about any item in this newsletter, or to contribute suggestions for future newsletters, please contact Cynthia Thomas at cynthia.thomas@oig.hhs.gov.

ACCOMPLISHMENTS: I&E 2007 HIGHLIGHTS

This newsletter highlights examples of significant work performed by I&E units in 2007. These reports reflect the I&E community's commitment to improving the efficiency and effectiveness of Government programs and operations.

Department of Commerce

"U.S. Dual-Use Export Controls for India Should Continue To Be Closely Monitored"

This review examined the effectiveness of U.S. controls on dual-use exports to India. Although OIG found that the interagency process to review export license applications for India was working well, OIG identified a number of weaknesses in the Bureau of Industry and Security's (BIS) administration of export controls for India including the following:

- Dual-use export control policies and practices for India were not fully transparent.
- BIS' end-use check program in India needed to be improved.
- BIS needed to enhance its efforts to ensure exporter compliance with license conditions.

BIS is taking action to address a number of the recommendations from OIG's report, which should strengthen the effectiveness of the U.S. Government's dual-use export controls in preventing the illegal transfer of sensitive U.S. technologies and information to India.

Department of Defense

"Report on Survey Regarding Post-Employment Government Restrictions"

This review examined the awareness and attitudes of DoD senior officials and the acquisition workforce concerning restrictions governing post-Government employment. On June 16, 2005, the DoD IG contracted with the Ethics Resource Center (ERC) to conduct the survey as requested by the DoD General Counsel. ERC surveyed 9,044 DoD civilian and military personnel – 2,050 General officers and Senior Executive Service officials and 6,994 General Service (GS)-12 through GS-15 civilians and military equivalent pay grades. ERC made the following observations:

- Although approximately 95 percent of respondents had worked in the Federal Government for more than 5 years, only 69 percent of GS-14/15 and military

equivalent grade respondents had received training on post-Government employment restrictions.

- Approximately 620 of 3,134 respondents stated that they knew someone who they believed had violated the restrictions.

- Only 159 respondents had reported the alleged violation and more than 70 respondents were dissatisfied with DoD's response to the reported behavior.

- Respondents believed that they understood the post-Government employment restrictions but did not believe that other DoD personnel fully understood, or always complied with, the restrictions

DOD IG recommended that the DoD Standards of Conduct Office periodically conduct a survey of the acquisition workforce and senior officials to gauge the effectiveness of training on post-Government employment restrictions. Particular training and communication emphasis should be placed on violations that represent the highest risk to the Department.

Department of Energy "Work Order Estimates and Cost Issues for Site Support Services at Los Alamos National Laboratory"

This review substantiated allegations of poor cost estimating and incorrect charges of labor and materials by OIG found that from January 2005 through April 2007 actual costs exceeded estimated costs for work order tasks by more than 20 percent in 71,025 out of 94,561 cases. OIG also identified specific examples of the subcontractor charging questionable, inappropriate, excessive, or unsupported labor and materials for laboratory work orders. Additionally, OIG found internal control weaknesses associated with the laboratory's work control system, which may have contributed to problems with work order charges and costs.

Department of Health & Human Services

"South Florida Suppliers' Compliance With Medicare Standards: Results From Unannounced Visits"

This review focused on the compliance of suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) with selected Medicare requirements in three South Florida counties. OIG inspected 1,581 suppliers to assess their compliance with the following selected Medicare supplier standards

- maintain a physical facility
- be open and staffed during business hours
- have a visible sign
- post hours of operation
- maintain a listed telephone number

OIG found that 45 percent of DMEPOS suppliers did not comply with at least one of the five standards reviewed. OIG recommended that the Centers for Medicare & Medicaid Services (CMS) strengthen the supplier enrollment process and ensure that suppliers meet Medicare standards through several actions, which include conducting more unannounced site visits and out-of-cycle inspections, performing more rigorous background checks of applicants, increasing the prepayment review of DMEPOS claims, and deactivating the Medicare billing numbers of DMEPOS suppliers that have been inactive for a 90-day period. CMS agreed with the options recommended by OIG and is taking several steps to strengthen the Medicare DMEPOS supplier standards.

Department of Interior

Bureau of Indian Affairs (BIA) / Law Enforcement Program

The Department of Interior OIG conducted Program Assessment Rating Tool (PART) Progress Evaluations. Federal agencies use PART, a standard questionnaire, to submit Federal program information to the Office of Management and Budget (OMB). OMB uses the information to determine program effectiveness, followed by recommended improvements for rated programs and follow-up on those improvements. OIG examined the Bureau of Indian Affairs (BIA)/ Law Enforcement Program to suggest improvement for the pro-

gram. OIG reviewed the program in 2006 and observed some progress toward implementing each of OMB's recommendations. Specifically, the program has:

- drafted an interagency agreement to coordinate activities with the Department of Justice's Community Oriented Policing Services program,
- developed a prototype system for collection of performance data, and
- completed numerous reviews and inspections of field activities.

National Aeronautics and Space Administration

"Effective Inspection Program Key to Improving Laboratory Safety at Glenn Research Center"

This review focused on laboratory safety and the process for reviewing, approving, and maintaining safety permits for Glenn laboratory operations. OIG found that the Glenn laboratory inspection program was not effectively identifying or following up on all incidents of noncompliance. Specifically, OIG identified incidents of noncompliance in each of the 22 laboratories reviewed. OIG determined that the Safety, Health, and Environmental Division was not inspecting all of the Glenn laboratories because its laboratory universe was not comprehensive; its list contained 192 fewer laboratories than those identified by the Glenn Facilities Division. In addition, although Glenn guidance required corrective action plans for safety violations remaining open after 30 days, 87 violations greater than 30 days did not have plans, and 9 violations had the potential to cause injury or damage to personnel or equipment. After the review, NASA management initiated a comprehensive review of its chemical management and laboratory safety programs and effectively mitigated any immediate health and/or safety threats by issuing stop-work orders.

Peace Corps

"Evaluation of Peace Corps Volunteer Safety and Security"

This review involved field work at Peace Corps Headquarters and 17 overseas posts. OIG determined that uneven implementation of Peace Corps' safety and security policies continue to persist 5 years after the Government Accountability Office first reported similar findings. The report discussed concerns about reporting crime data; disseminating information on crimes against volunteers; selecting and monitoring volunteers' sites; emergency action planning; and strategic planning related to safety and security.

Department of Veterans Affairs

"Review of Care and Death of a Veteran Patient, VA Medical Centers, St. Cloud and Minneapolis, Minnesota"

This review examined the care and death of an Operation Iraqi Freedom (OIF) veteran in Minnesota. In January 2007, a U.S. Marine Corps OIF veteran committed suicide in a friend's home. The patient had received extensive health care over the previous 20 months from the VA Medical Center (VAMC) in Minneapolis, Minnesota. Although a patient of the Minneapolis VAMC, the veteran visited the St. Cloud VAMC, 75 miles to the northwest of Minneapolis, for the first time 5 days before his death and started the process to be admitted to a St. Cloud VAMC elective residential treatment program. At the request of the Secretary and members of Congress, OIG performed a comprehensive inspection of the Minneapolis and St. Cloud VAMCs' health care provided to the patient and examined the circumstances of the patient's death. OIG made recommendations to improve the screening process for the St. Cloud VAMC elective residential program.

UPCOMING

If you would like to host the next I&E Roundtable, please contact Cynthia Thomas at 410-786-7896 or cynthia.thomas@oig.hhs.gov.

I&E NEWS

The minutes from the I&E Roundtable meeting hosted by HHS on November 15, 2007, are now posted on the IGNET.