



# **Office of Inspector General**

## **Semiannual Report to Congress**

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**October 1, 1998 – March 31, 1999**

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## FOREWORD

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I am pleased to submit the semiannual report on the activities of the Office of Inspector General (OIG) for the period ended March 31, 1999. 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 \$474 million in monetary benefits, for an OIG return on investment of \$27 for every dollar expended. A particularly noteworthy accomplishment was an audit of benefit payments to incarcerated veterans that identified past and future overpayments exceeding \$170 million that could, if recovered and/or avoided, be used to improve services to veterans. Additional OIG accomplishments during the period included 70 indictments, 57 criminal convictions, and 141 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 Veterans Health Administration's deployment of Quality Management staff and the implementation of the Patient Safety Improvement Policy. Healthcare inspectors conducted proactive reviews of essential aspects of VHA clinical operations and patient treatment processes and made recommendations for improvement.

OIG has recently initiated a new program called the 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.

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

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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, 1999. Following are the statistical highlights of OIG activities and some of the major accomplishments during the reporting period by OIG component.

<u>DOLLAR IMPACT</u>	<u>Dollars in Millions</u>
Funds Put to Better Use.....	\$456.0
Dollar Recoveries.....	\$9.1
Fines, Penalties, Restitutions, and Civil Judgments.....	\$9.5
<u>RETURN ON INVESTMENT</u>	
Dollar Impact (\$474.6M) / Cost of OIG Operations (\$17.4M).....	27 : 1
<u>OTHER IMPACT</u>	
Indictments.....	70
Convictions.....	57
Administrative Sanctions.....	141
<u>ACTIVITIES</u>	
Reports Issued	
Combined Assessment Program.....	1
Audits.....	24
Contract Reviews.....	19
Healthcare Inspections.....	20
Administrative Investigations.....	8
Investigative Cases	
Opened.....	177
Closed.....	106
Hotline Activities	
Contacts.....	7,470
Cases Opened.....	323
Cases Closed.....	296

### OFFICE OF INVESTIGATIONS

During the semiannual period, and as part of an overall OIG reorganization, the former Special Inquiries staff of the Hotline and Special Inquiries Division was transferred to the Office of Investigations. The transfer was predicated upon the theory that all investigative activity, whether criminal or administrative in nature, should be located in one OIG component. Further, since many criminal investigations uncover collateral administrative violations, and vice-versa, the staffs of each previously separate activity could provide specialized expertise and cross-disciplinary training when multiple violations were found.

Therefore, the Office of Investigations is now comprised of a Criminal Investigations Division and an Administrative Investigations Division. The Analysis and Oversight Division continues with oversight responsibilities of all operations through a detailed, recurring inspection program; operation of the Forensic Document Laboratory; policy and procedures updates; analysis of referrals and investigative results; operation of the National Crime Information Center and National Law Enforcement Telecommunications System computers; representation to the Financial Crimes Criminal Enforcement Network; and files operation and maintenance. Criminal investigative priority continues to be given to cases of patient abuse, instances where incapacitated veterans fall victim to unscrupulous fiduciaries, public corruption, and major thefts. Immediate response to these types of allegations 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 Office of Investigations closed 106 criminal investigations resulting in 127 judicial actions and over \$12.6 million returned or saved. The Administrative Investigations Division staff investigates allegations, generally against high-ranking VA officials, concerning misconduct and other matters of interest to the Congress, VA Secretary, VA managers, media, and the general public. Five administrative investigations completed this semiannual period were initiated at the request of individual members of Congress. During the reporting period, the division closed 22 cases. Six of these cases had Congressional interest. Staff issued 10 reports and 1 administrative letter. These resulted in administrative action taken (or planned to be taken) against 18 high-ranking officials and other employees, and 13 corrective actions taken (or planned to be 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 have been charged with various illegal activities: (i) A former VA medical center (VAMC) nurse in the critical care unit was indicted on 11 counts including the murder of 3 patients, the attempted murder of 2 other patients, assault, and obstruction of justice. (ii) An individual formerly employed as a VAMC Chief of Surgical Service was sentenced to 5 months' imprisonment, 36 months' supervised probation, and fined \$25,000 after being found guilty of involuntary manslaughter in a jury trial. The individual was found guilty of administering a lethal dose of potassium chloride to a veteran patient. (iii) A former VAMC licensed practical nurse pleaded guilty to charges of striking a 77 year-old veteran while he was a patient at the VAMC. (iv) A VAMC physician pleaded guilty after being indicted on one count of theft of Government property. The physician diverted approximately 45,620 doses of codeine over a 3½ year period by writing prescriptions for patients and taking them to the VA pharmacy, stating that he would personally deliver the drugs to the patients. (v) A VA outpatient clinic transportation clerk waived indictment and agreed to be charged in a five-count criminal information after being arrested on charges of accepting bribes. The individual had received and retained monetary gratuities from the owners of a medical transportation company in exchange for the award of transportation business from VA.

### Veterans Benefits Administration

The following investigations are examples of fraud relating to some of the benefits programs administrated by the Veterans Benefits Administration (VBA): (i) A former VA ratings specialist pleaded guilty to one count of theft of Government funds. Investigation disclosed that the individual created a record of a fictitious veteran in 1986 and proceeded to award the fictitious veteran benefits for service connected disabilities. He then had over \$624,000 in monthly benefits deposited into a savings account opened in the name of the fictitious veteran. (ii) A former VA Regional Office (VARO) supervisor pleaded guilty to a criminal information charging her with engaging in money laundering and other offenses. Investigation disclosed that the employee created computerized records, which fraudulently reflected that her fiancé was a 100 percent service-connected disabled veteran. She then caused VA to

issue checks and make direct-deposit payments totaling more than \$600,000 into a bank account she had opened in both their names. (iii) For almost 16 years, an individual who falsely certified to VA that he was unemployed in order to receive benefits actually worked continuously as a full-time fire alarm operator. The individual's false claims resulted in his collecting almost \$112,000 in VA compensation benefits, based on unemployability, to which he was not entitled. (iv) An individual acting as a VA fiduciary, court-appointed guardian, and social security representative payee to a number of elderly veterans pleaded guilty to mail fraud and misapplication of funds by a VA fiduciary. The individual wrongfully appropriated more than \$200,000 in funds belonging to the estates of six of her elderly veteran wards, five of whom were judged to be mentally incompetent. (v) An attorney was arrested pursuant to a nine-count indictment and subsequently pleaded guilty in connection with the theft of approximately \$120,000 from the guardianship account of a disabled World War II veteran. Investigation disclosed that in 1993, the individual started withdrawing large amounts of money from the veteran's account to pay for his personal expenditures. (vi) A plea agreement and criminal information were filed charging an individual with misappropriation by a fiduciary. Investigation disclosed that the individual, over a 1-year period, embezzled approximately \$104,000 from three incompetent veterans.

### National Cemetery Administration

(i) A VA national cemetery caretaker pleaded guilty to charges of witness tampering. An accomplice, employed as a foreman at the cemetery, earlier pleaded guilty to related charges of bribery. Investigation disclosed that the foreman solicited and accepted bribe money from a probationer who was assigned by a state court to perform community service at the cemetery. The probationer's time and attendance record was falsified by the foreman. Both employees attempted on numerous occasions to prevent witness cooperation with the investigating agents. (ii) An individual resigned as a VA program assistant after being confronted by investigators with evidence of her misuse of two Visa SmartPay cards. A joint VA OIG and FBI investigation determined the employee illegally used two Visa cards assigned to her, for support of administration operations, to purchase over \$284,000 in computers and electronic entertainment equipment which she converted to personal use or resold for 50 percent of market value for personal gain. She also used the cards to cover some personal expenses. Criminal charges are pending.

## **OFFICE OF AUDIT**

### Audit Saved or Identified Improved Uses for \$458 Million

Audits and evaluations were conducted that focus on determining how programs can work better, while improving service to veterans. During this reporting period, 24 performance and financial audits and evaluations and 19 contract reviews identified opportunities to save or make better use of \$458 million in monetary benefits. The Office of Audit returned \$57 for every dollar spent on performance and financial audits, and \$10 and \$63 for every dollar spent on postaward and preaward contract reviews, respectively.

### Veterans Health Administration

During this period, nine audit or evaluation reports were issued relating to health care issues. Our reviews of health care found that: (i) VHA's reorganization of Veterans Integrated Service Network (VISN) 10 was proceeding in accordance with the Under Secretary's plan, but weaknesses in patient enrollment, reporting, and resource allocation needed to be corrected; (ii) local VA medical facilities were not implementing a new VHA cost and management information system as intended by its designers, affecting the ability to achieve the full potential of the \$140 million system; (iii) significant efforts were made to reduce inpatient infrastructure and increase ambulatory care infrastructure at medical centers

reviewed, but cost accounting data was not adequate to identify and quantify the sources of funding for investments; and (iv) VHA could increase funding available for health care by about \$14 million by improved oversight and monitoring of means testing, billing, and collection of Income Verification Match (IVM) program referrals. Fourteen projects were begun or ongoing during the period that will be completed in future reporting periods. These projects focus on: (i) the effectiveness of VISN and medical facility operations and implementation of VHA organizational goals and objectives, (ii) the accuracy and reliability of VHA performance measures, and (iii) fee basis medical claims.

### Veterans Benefits Administration

We issued five audit or evaluation reports during this period addressing accuracy, timeliness, and quality of service to veterans, dependents, and survivors. These reviews found that: (i) past and future Compensation and Pension (C&P) overpayments could exceed \$170 million because VBA did not implement a systematic approach to identify veterans incarcerated or released from prisons; and (ii) VBA measurement of claims processing timeliness was inaccurate, reporting better timeliness than actually provided. During the period six projects were begun or ongoing that will be completed in future reporting periods. These projects are evaluating: (i) VBA disability rating decisions, (ii) compliance with VA mortgage underwriting standards by private mortgage lenders, and (iii) VBA's implementation of Government Performance and Results Act (GPRA).

### Office of Financial Management

We issued 10 reports addressing financial and acquisition issues during the period. We qualified our opinion in our audit of the Department's Consolidated Financial Statements (CFS) for Fiscal Year (FY) 1998 and made recommendations that will assist the VA Chief Financial Officer in taking the steps necessary to remove the qualifications. Our review of VA's Government Purchase Card program found VA did not achieve the cost-efficiencies expected from the program and we recommended steps to achieve additional staff reductions totaling over \$22 million. We also reported that VHA could reduce medical supply inventories by more than \$75 million through more effective inventory management. During the period eight projects were begun or ongoing that will be completed in future reporting periods. These projects include our continuing audit of the adequacy of VA financial management as required by the Chief Financial Officers Act, and evaluation of the management of prosthetics and pharmaceutical supply inventories.

### Contract Review and Evaluation

During the period we completed 19 contract reviews – 6 preaward and 13 postaward reviews. The postaward reviews had recoveries of \$8.6 million, almost all of which have been returned to VA to fund programs. Preaward reviews of contractors' proposals resulted in recommendations that can assist contracting officers in saving \$23.9 million in contract costs.

## **OFFICE OF HEALTHCARE INSPECTIONS**

The Office of Healthcare Inspections' (OHI) program evaluations, hotline inspections, and quality program assistance reviews, show that VHA clinicians provide generally good care to an aging, chronically infirm veteran population in a variety of clinical care environments.

## Program Reviews

We conducted three health care program evaluations. (i) Our analysis of VHA's quality management (QM) resources and organization showed that VHA QM employees work hard to ensure the provision of good patient care, but the QM program needs to be integrated more fully into the health care system. QM employees need to be better trained in more complex ADP systems usage, and appropriately skilled staffing is needed at the headquarters, VISN, and VAMC levels in order to manage the diverse and complex QM workload. (ii) Similarly, our analysis of VHA employees' implementation of selected aspects of the patient safety improvement policy showed that employees know of their requirement to report and explore serious patient incidents. Managers have developed a patient safety alert process that is generally effective in providing critical safety information to employees who care for patients directly. However, mid-level managers do not always communicate these messages to lower level employees. (iii) We found that VAMC senior clinicians who are responsible for overseeing State Veterans Home operations do not usually adhere to nationwide guidance. Serious patient care discrepancies that VA inspectors identify in State Veterans Homes are often ignored, or not followed up to ensure the provision of excellent care to eligible veterans.

## Quality Program Assistance Reviews

Our Quality Program Assistance reviews at three VAMCs found that managers are generally working collaboratively to ensure that veterans have access to high quality, low cost health care. With the exception of one Northeastern VAMC, employees generally support the changes, but the rapid pace and broad scope of changes are negatively affecting employee morale. In the one exception to this finding, employees and patients alike were frightened that the magnitude of changes and budget reductions would threaten the quality of care for veterans. However, they virtually all asserted that the quality of care at the medical center is excellent.

## **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 7,470 contacts. Of this number, Hotline staff opened 323 cases, and completed 296 cases of which 69 contained substantiated allegations. Hotline staff also generated 159 letters responding to inquiries received from members of the Senate and House of Representatives. Hotline staff recorded 28 administrative sanctions against employees and 35 corrective actions taken by management to improve VA operations and activities. The Hotline reviews found that some physicians engaged in improper outside employment activities, and several instances of misconduct by professional staff in the care and treatment of veteran patients. Hotline reviews also identified that illegal gambling occurred at one facility, and the inquiries uncovered deficiencies regarding several VA contracts. The reviews also identified problems with several compensation and pension cases that warranted management attention.

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, Data Analysis staff processed 566 requests for data and information. These requests are



often the first step in more comprehensive reviews by OIG activities that result in solutions beneficial to the VA, or the identification of fraud, waste, and abuse. The Data Analysis Section also renders assistance to the investigative components of other agencies. For example, Data Analysis staff provided assistance to Health and Human Services agents and other governmental investigators on a variety of billing fraud cases.

### Followup on OIG Reports

The Operational Support Division is responsible for obtaining implementation actions on audits, inspections, and reviews with over \$1.2 billion of actual or potential monetary benefits as of March 31, 1999. Of this amount \$1 billion is resolved, but not yet realized as VA has agreed to implement the recommendations, but has not yet done so. In addition, \$230 million relates to unresolved reviews awaiting contract resolution by VA contracting officers. During this reporting period, the Division took action to close 48 internal reports issued in this and prior periods, with 169 recommendations and a monetary benefit of \$218 million, after obtaining information that showed management officials had fully implemented corrective actions.

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# VA AND OIG MISSION, ORGANIZATION, AND RESOURCES

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## The Department of Veterans Affairs (VA)

### Background

In one form or another, American governments have provided veterans benefits since even 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.

## Organization

VA has three administrations that operate direct services to 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, including:

- Financial Management (Budget, Finance, Acquisition and Materiel Management (A&MM)),
- Information and Technology,
- Planning and Analysis,
- Human Resources and Administration (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 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 1999, VA has 205,413 employees and a \$44 billion budget. There are an estimated 25.9 million living veterans and the provision of legislatively mandated services to them is a massive operation. To serve our Nation's veterans, VA maintains facilities in every state of the union and the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Philippines.

Approximately 189,000 of VA's employees work in the health care system. Health care accounts for \$18 billion (approximately 42 percent) of VA's budget in FY 1999. VHA provides care to an average of 62,000 inpatients daily. During FY 1999, slightly more than 38 million episodes of care are estimated for outpatients. There are 172 hospitals, 722 outpatient clinics, 132 nursing home units, and 40 domiciliaries.

Veterans benefits are funded at \$24 billion (almost 55 percent) of VA's budget in FY 1999. The 11,273 employees of VBA provide benefits to veterans and their families. Approximately 2.5 million veterans and their beneficiaries receive compensation benefits valued at over \$18 billion. Also over \$3 billion in pension benefits are provided to veterans and survivors. VA life insurance programs have 4.7 million policies in force with a face value of over \$467 billion. Almost 300,000 home loans were guaranteed, with a value of almost \$33 billion.

The National Cemetery Administration currently operates and maintains 115 cemeteries and has 1,369 employees in FY 1999. Operations of NCA and all of VA's burial benefits account for approximately \$264 million of VA's \$44 billion budget. There are almost 80,000 interments in VA cemeteries each year. Approximately 337,000 headstones and markers are 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 995-452) 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**

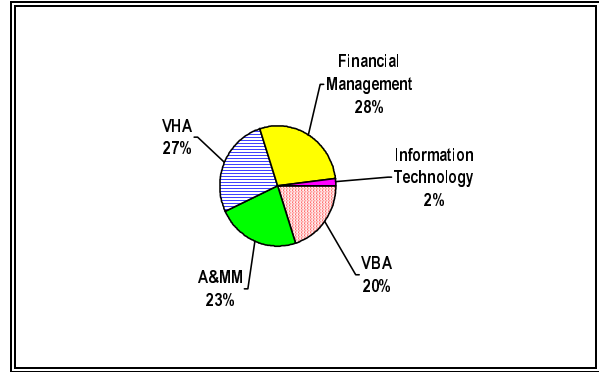
Allocated full time equivalent (FTE) for the FY 1999 staffing plan is as follows:

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

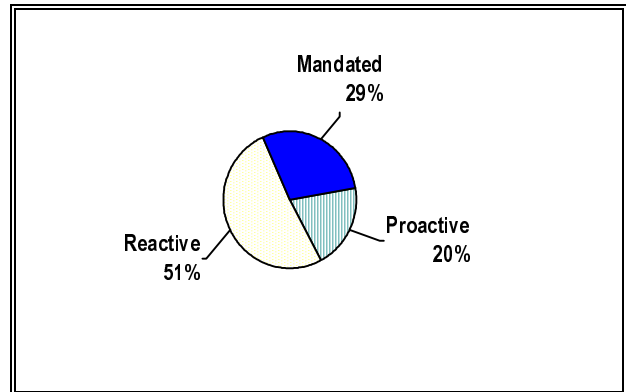
\* Does not include 24 reimbursable FTE.

FY 1999 funding for OIG operations is \$38.4 million, with \$36 million from appropriations and \$2.4 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; 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 and Healthcare Inspections 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.

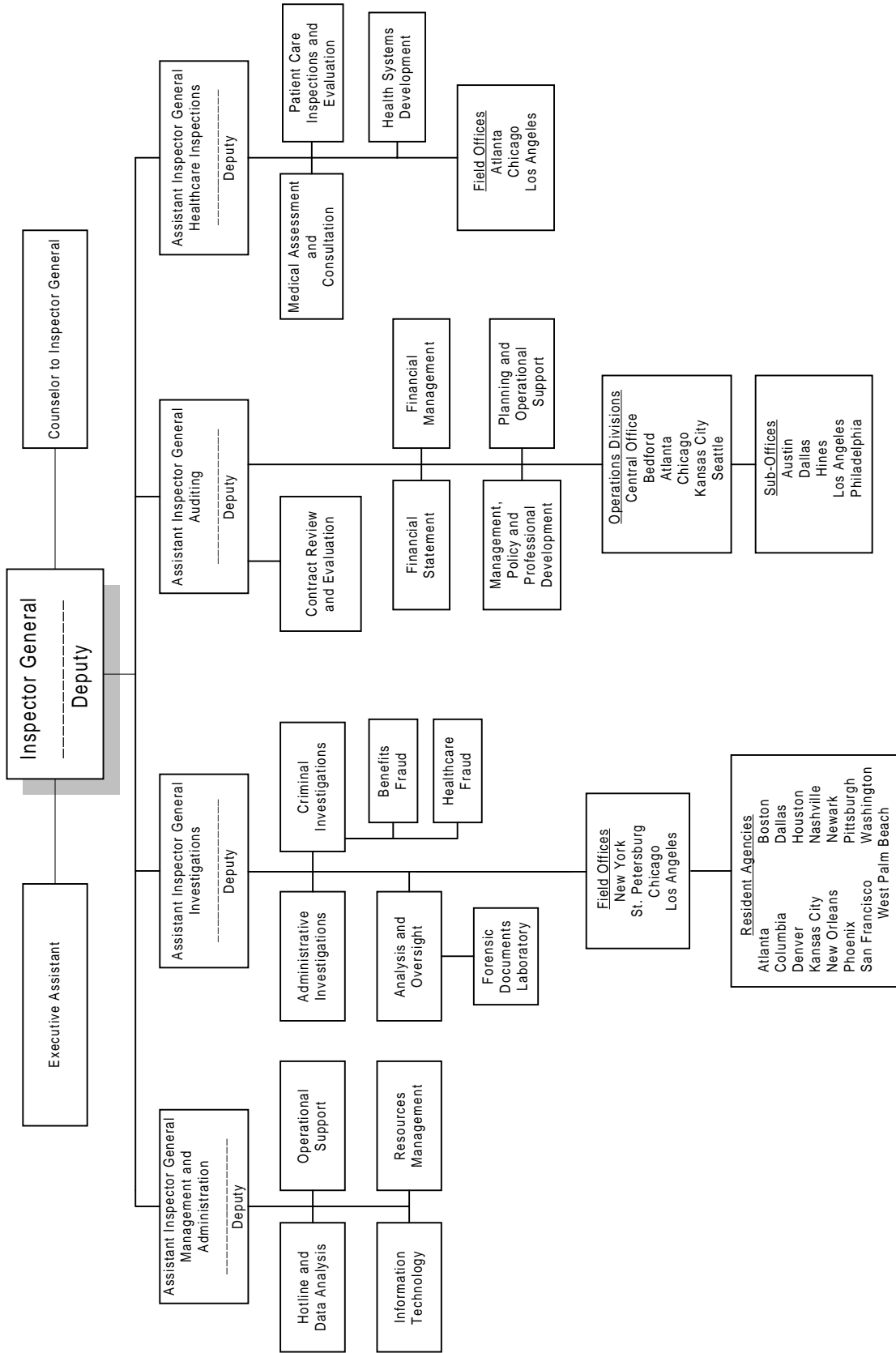
## **OIG Mission Statement**

*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 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**



## VA and OIG Mission, Organization and Resources

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# COMBINED ASSESSMENT PROGRAM

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## Combined Assessment Program Overview

As part of the OIG's efforts to ensure that quality healthcare service is provided to our Nation's veterans, the OIG recently initiated a new program to evaluate the quality, efficiency, and effectiveness of VA medical care – the Combined Assessment Program (CAP). This program provides recurring cyclical oversight of VA medical facility operations, focusing on the effectiveness and quality 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 will provide an independent and objective assessment of key operations and programs at VA medical centers on a cyclical basis.

A special agent from the Office of Investigations conducts a Fraud and Integrity Awareness Briefing. The purpose of this briefing is to provide key staff of the medical center with insight into the types of fraudulent activities that can occur in VA programs. The briefing includes an overview and case specific examples of fraud affecting healthcare procurements, false claims, conflict of interest, bribery, and illegal gratuities. Office of Investigations personnel will 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 are working effectively. Auditors assess key areas of concern which will be derived from a concentrated and continuing

analysis of VHA, VISN, and medical center 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.

## VAMC Martinsburg, West Virginia Review

The OIG CAP team visited VAMC Martinsburg from January 11 through January 15, 1999. The following are highlights of our observations and testing of management operations that were identified as areas that appear vulnerable and in need of greater management attention. These areas include:

Quality Program Assessment - The results of the QPA identified several areas of concern that affect the quality of patient care; these include clinical staffing issues, patient waiting time, patient privacy, and reporting of medication errors.

Management Control Issues - A number of areas were identified where management controls and oversight should be strengthened to correct and prevent some internal control deficiencies, enhance revenue collections, ensure staff are properly trained, or improve the perceptions of



## Combined Assessment Program

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some staff regarding the fairness of promotions and awards. Some specific areas where controls need to be strengthened included: patient safety and security of personal property - Domiciliary; purchase cards - reconciliation and certifications; unauthorized use of the purchase card; accounts receivable - write off and third party follow-up; time and attendance - training and supervision; agent cashier - excess funds; and, personnel management - pending actions and awards criteria.

Fraud and Integrity Awareness and Hotline Allegations - Two Fraud and Integrity Awareness Briefings were conducted that discussed issues concerning the recognition of fraudulent situations, referral to the Office of Investigations, and the type of information needed in making a complaint or referral. The CAP team also initiated a review of hotline allegations that fell into five general areas. The results of that review will be addressed in a separate report.

We made a series of observations and recommendations that we believe warrant management attention. The Director generally agreed to address the areas of concern. The OIG may follow up at a later date to evaluate corrective actions taken. (*Combined Assessment Program Review VAMC Martinsburg, West Virginia, Report No. 9IG-CAP-501, 3/31/99*)

Group Seated & Standing  
[photo not available electronically]

Members of first OIG CAP Team  
Back row: Jeff Reaves, Linda DeLong, John Cintolo, Philip McDonald  
Middle row: Jackie Stumbris, Myra Kennedy, Jim Marchand, Carl Looby  
Front row: Pat Christ, Del Levy, Bill Withrow, Tom Cargill  
Absent from photo: Lisa Seibert, Marion Slachta, Theresa King

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# OFFICE OF INVESTIGATIONS

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## Mission Statement

*Conduct investigations of criminal and administrative 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 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.

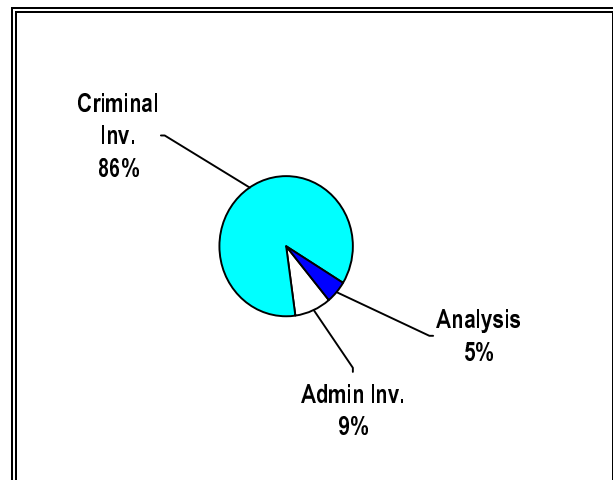
I. Criminal Investigations Division - The Division is primarily responsible for conducting investigations into allegations of criminal activities related to the programs and operations of VA. Criminal violations are referred to the Department of Justice for prosecution.

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 and the operation of the Forensic Document Laboratory. 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.



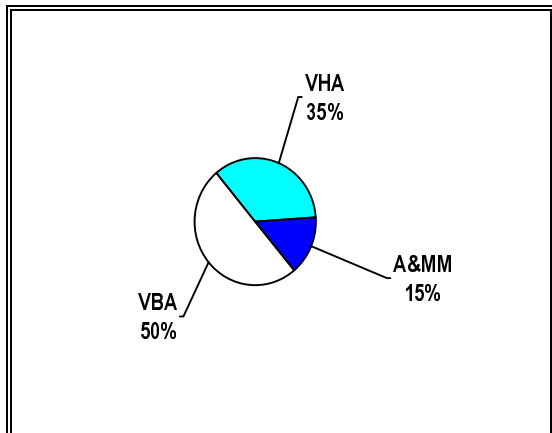
## I. CRIMINAL INVESTIGATIONS DIVISION

### 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 93 FTE for its headquarters and 19 field locations. These individuals are deployed in the following program areas:



## Overall Performance

### Output

- 106 investigations were closed during the reporting period.

### Outcome

- Indictments - 70
- Convictions - 57
- Monetary Benefits - \$12.6 million
- Administrative Sanctions - 82

### Cost Effectiveness

- The average cost of conducting the 106 closed investigations was \$10,607. Each investigation averaged a return of \$74,113, resulting in approximately \$7 returned for every \$1 spent.

### Timeliness

- Average work days from receipt of allegation to initiation of investigation averages 31 days against a goal of 30 days.
- Average work days from initiation of investigation to referral to an assistant U.S. attorney was 272 days which did not meet our goal of 182 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 strongly agree and 1.0 means strongly disagree).

Following are summaries of some of the investigations conducted during the reporting period by VA component. We discuss VHA, VBA, NCA, and the Office of Human Resources and Administration. This is followed by a summary of the work performed by the OIG Forensic Document Laboratory, which provides technical support and services to the Criminal Investigations Division, and to the VA staff.

## Veterans Health Administration

*Fraud and other criminal activities committed against VHA encompass patient abuse, theft of Government property, drug diversion, bribery/kickback activities by employees and contractors, false billings, inferior products, and so forth.*

*During the reporting period, we have continued our support to VHA in its attempt to remove from the workers' compensation rolls those employees fraudulently accepting benefits. The Office of Investigations investigates those instances of criminal activity against VHA that have the greatest impact and most deterrent value.*

### Employee Integrity

#### Theft/Diversions of Pharmaceuticals

- A VAMC physician pleaded guilty after being indicted on one count of theft of Government property. A joint VA OIG and

Drug Enforcement Administration investigation disclosed that the physician engaged in a scheme to divert codeine tablets for his own use. The physician diverted approximately 45,620 doses of codeine over a 3 ½ year period by writing prescriptions for patients and taking them to the VA pharmacy, stating that he would personally deliver the drugs to the patients.

- A former VAMC registered nurse entered a plea agreement, wherein he agreed to plead guilty to one charge of theft of Government property. A VA OIG investigation disclosed that the nurse diverted Morphine intended for patients for his personal use.
- A VAMC supervisory pharmacist pleaded guilty to one count of theft of Government property and was subsequently sentenced to 4 months' home detention, 36 months' probation, and was ordered to pay \$3,224 in restitution. A joint VA OIG and state Bureau of Narcotic Enforcement investigation disclosed that, for more than 2 years, the individual accessed computers at the VAMC and placed orders for drugs to be sent by mail to his home in the name of a veteran patient. A search warrant was executed on the individual's residence and a substantial quantity of medical supplies and pharmaceuticals, including controlled narcotics, were found and seized. The individual admitted that he had stolen pharmaceuticals, including the controlled narcotics, from the VAMC.

#### Use/Sale of Illegal Drugs

- A former VAMC housekeeping aide pleaded guilty to one count of possession of narcotics (cocaine & marijuana) and to a separate charge of possession of crack cocaine. After being arrested by VA OIG special agents, she was placed in a court-ordered drug treatment program and was subsequently sentenced to 1 year's probation. A second individual employed as a VAMC food service worker also pleaded guilty to one count of possession of narcotics. A

joint investigation by VA OIG and the Federal Bureau of Investigation (FBI) disclosed that both were involved with a group of other individuals employed at the VAMC who regularly sold marijuana and cocaine to patients at the VAMC, and used illicit drugs on hospital grounds. Other individuals involved in the case are awaiting sentencing or currently in drug treatment.

- A VA OIG proactive undercover investigation in the area of a VAMC resulted in the arrest and conviction of an individual in state court. The individual was arrested for the distribution of a controlled substance (Morphine) in and near the VAMC. The suspect was sentenced to 12 months' incarceration and has no affiliation to VA.

#### Theft and Embezzlement

A criminal complaint was filed charging an individual with one count each of theft, false statements, and bank fraud. The individual was employed as the secretary/treasurer of an American Federation of Government Employees union office located in a VAMC. A VA OIG investigation disclosed that, over a 2-year period, the individual embezzled approximately \$20,000 from the union's bank account.

#### Acceptance of Bribes, Gratuities, Conflicts of Interest

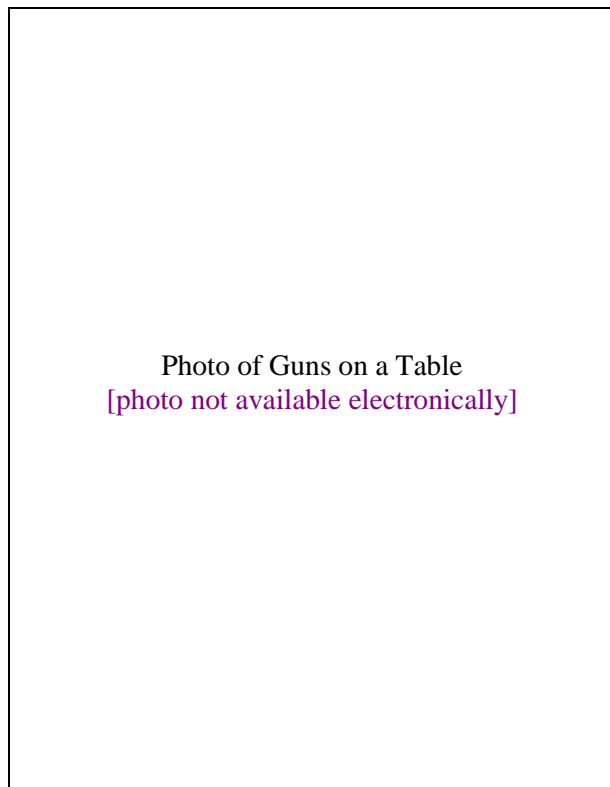
A VA outpatient clinic medical transportation clerk waived indictment and agreed to be charged in a five-count criminal information after being arrested on charges of accepting bribes. A joint VA OIG and FBI investigation disclosed that the individual had received and retained monetary gratuities from the owners of a medical transportation company in exchange for the award of transportation business from VA. As travel clerk, the individual's duties included arranging patient transportation by

## Office of Investigations

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initiating an authorization for transportation service, awarding the service to local vendors, and subsequently approving and submitting the appropriate invoices for payment to the VAMC fiscal office. The investigation continues.

### Workers' Compensation Benefits Fraud



The cache of weapons seized during the execution of a search warrant

- A former veterans outreach specialist was sentenced in state court to 5 years' probation after pleading guilty to one count of criminal possession of a weapon. The guilty plea was the result of a joint investigation conducted by VA OIG, the Department of Labor (DOL) OIG, the Bureau of Alcohol, Tobacco, and Firearms (BATF), and local police. Handguns were discovered in the individual's home during the execution of a Federal search warrant as part of

a workers' compensation benefits fraud investigation. One of the handguns was found to have a defaced serial number, which the BATF laboratory was able to raise and determine the gun was reported stolen from the home of a retired police officer. The individual had previously pleaded guilty to Federal fraud charges after he admitted illegally collecting over \$320,000 in workers' compensation benefits by falsely reporting an inability to work because of an injury sustained while working for VA. A VA OIG investigation found that during the time he was collecting workers' compensation benefits, he was working at a variety of different jobs, including counselor at a children's school, operator of a transportation company, and as a self-employed psychologist.

- A former VAMC motor vehicle operator has paid a total of \$182,820 to the Government in restitution as a result of a prior guilty plea to charges of workers' compensation fraud. He had reported that he had been in a motor vehicle accident while on duty and sustained injuries to his neck and lower back, thus allowing him to collect compensation for his inability to work. While collecting workers' compensation benefits, however, he was observed working at rental properties that he owned and at a restaurant, which he owned and operated.

- An individual was sentenced to 30 months' imprisonment and was ordered to pay \$32,955 in restitution after pleading guilty to charges of forgery of a U.S. Treasury check and possession of a firearm by a convicted felon. A joint investigation by VA OIG, DOL OIG, U.S. Postal Inspection Service, and BATF determined that the individual fraudulently continued to receive and negotiate U.S. Treasury checks that had been issued to his deceased wife, a former VA nurse, for workers' compensation benefits.

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## Other Employee Misconduct

- A former VAMC registered nurse was found guilty of making false statements after a 4-day jury trial. A VA OIG investigation, initiated pursuant to a complaint from a patient at the VAMC, disclosed that the nurse, formerly assigned to the long-term psychiatric unit at the VAMC, routinely slept during her shifts and then made false statements to VA OIG special agents when questioned on the subject. For the majority of the nights she worked, she was the only registered nurse assigned to the unit and the only staff member allowed to dispense medications to patients.
- A former VAMC information security officer pleaded guilty to possession of child pornography. A VA OIG investigation disclosed that the individual, while on duty, had downloaded multiple images of child pornography and stored them on his Government computer hard drive. As a result of the investigation, the individual applied for and received early retirement. He could be sentenced to a maximum of 15 years' imprisonment and a fine of \$250,000.
- A former VAMC chief of psychiatry interrupted his trial and pleaded guilty in state court to 36 felony charges, including theft by taking, theft of services, making false statements, and a single Racketeer Influenced and Corrupt Organizations violation. He was indicted previously in a 172-count indictment. As part of a plea agreement, he was sentenced to 15 years' imprisonment, 5 years' probation, fined \$125,000, and ordered to pay \$4.26 million in restitution and forfeitures, and agreed to surrender his medical license and never to engage in patient studies again. The charges stemmed from a scheme where the psychiatrist and his partner made false statements to VA to utilize VA facilities and patients in conjunction with pharmaceutical drug research. Funds from the drug companies were paid to a shell

corporation created by the psychiatrist as part of the scheme. Neither VA nor its affiliated university medical school that was also victimized knew of the shell corporation. The partner in the scheme previously pleaded guilty to similar charges and was ordered to pay over \$1.1 million in restitution, forfeitures, and fines and ordered never again to engage in research activities.

- A former VAMC registered nurse was sentenced to 3 months' incarceration and 2 years' supervised release after pleading guilty earlier this year to one count of providing false statements. During a VA OIG investigation into his nursing background, he disclosed to investigators that he submitted fraudulent credentials to obtain his position as a VAMC staff nurse. Throughout his 13-year career, he continued to update those false credentials to obtain promotions. Through promotions, the nurse eventually was elevated to a position responsible for coordinating and managing patient care in two intensive care units at the VAMC.
- A former VAMC maintenance supervisor was sentenced to 3 years' probation and ordered to pay \$20,000 in restitution after pleading guilty to one count of mail fraud. The former maintenance supervisor was the Government's witness in a trial against two other individuals who worked for VA vendors that supplied construction materials to VA. The owner of one of the companies was convicted on one count of mail fraud; the second individual, the sales representative for another company, was found guilty on two counts of mail fraud. The convictions were the result of a joint VA OIG and FBI investigation which disclosed that the maintenance supervisor and the two vendors participated in a scheme that used the mail to further various fraudulent acts against VA, including the submission of false claims and the diversion of VA goods and property for personal use.

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- A VAMC compensated work therapy worker was indicted and subsequently arrested on charges of using VAMC computers to download pornography. A joint VA OIG and VA police investigation disclosed that, on at least two occasions, the individual utilized computers located in the medical center library for the purposes of accessing and printing more than 50 pornographic images, some of which portrayed images of children.

### Patient Abuse/Death

- A former VAMC nurse in a critical care unit was indicted on 11 counts including the murder of three patients, the attempted murder of two other patients, assault, and obstruction of justice. She previously had been found guilty of making a telephone bomb threat to the VAMC in retaliation against co-workers who reported her as a suspect in numerous deaths at the facility and was subsequently sentenced to 15 months in prison and 3 years' supervised release. When she is tried on the murder charges, she could face multiple life sentences or death. A VA OIG investigation into the suspicious deaths disclosed that she was on duty at the time each of the deaths occurred. Further investigation involved the exhumation of some of the deceased veterans and tests by experts in the fields of pathology and toxicology. The indictment charges that the nurse used a heart stimulant to murder or assault the patients in her care. A trial date is pending.

- A former VAMC chief of surgical service was sentenced to 5 months' imprisonment, 36 months' supervised probation, and fined \$25,000 after being found guilty of involuntary manslaughter in a jury trial. As a result of a joint VA OIG and FBI investigation, the individual was found guilty of administering a lethal dose of potassium chloride to a veteran patient that he had operated on previously. The lethal administration was given in spite of warnings from other caregivers in attendance.

- A licensed practical nurse, formerly employed for 18 years by VA, and a nursing assistant were both indicted on charges of assault on patients in a VAMC. The licensed practical nurse subsequently pleaded guilty to charges of striking a 77 year-old veteran while he was a patient at the VAMC, and at sentencing could face up to 6 months in prison and a fine of \$5,000. A joint VA OIG and FBI investigation disclosed that the employees struck and otherwise abused patients in separate incidents, causing a facial laceration in one of the cases. The investigation is continuing.

### Health Care Fraud

A doctor was sentenced to 5 months' imprisonment, 5 months in a halfway house, and 3 years' supervised release for his role in committing insurance fraud. He previously had entered a plea of guilty to mail fraud. A joint VA OIG and FBI investigation disclosed that the

headline from the Boston Globe

[photo not available electronically]

doctor, along with another doctor facing separate charges, submitted false bills in order to receive insurance payments for elective, cosmetic procedures not normally covered by insurance providers. A third person involved as a marketer in the scheme also was charged and agreed to plead guilty to mail fraud. The marketer acknowledged that several surgery centers paid her a commission to recruit patients, including VA employees, who were promised free plastic surgery procedures. Investigation revealed that marketers would refer patients to one of the surgery centers with the understanding that the center and doctors would bill the patients' insurance companies for the cosmetic surgeries. The marketers also would arrange for the patients' travel and hotel accommodations. In order to obtain payments for the cosmetic surgeries, the doctors falsely diagnosed the patients to justify the billings as "medically necessary" procedures. As part of the scheme, the two doctors also submitted bills that claimed they had been assisted by another surgeon during various procedures when, in fact, they never had any assistance.

- Two former nursing home managers who provided contractual care for VA patients were convicted on charges of filing false claims, mail and wire fraud, money laundering, and filing false tax returns. A joint VA OIG, Internal Revenue Service, and State Medicaid Fraud Bureau investigation disclosed that the two billed VA and Medicaid for the care of patients who had either been discharged or who had died. One of the individuals remains in jail pending sentencing; both are to be sentenced shortly and face potential fines and prison terms. The former owner of the nursing home settled a civil suit brought by the Government, paying \$1 million in damages and penalties.

### **Theft of Government Property**

A VAMC carpenter resigned from his position after being arrested on charges of theft of

Government property. A VA OIG investigation disclosed that, over a 2-year period, the carpenter stole 16 air conditioners, valued at approximately \$8,000, from the VAMC for his personal use and monetary gain. VA OIG special agents confiscated five air conditioners from an auto repair shop where the carpenter had hidden them in an attempt to avoid detection. The remaining air conditioners were sold or given away. The individual was released on bond, pending a court appearance.

### **Construction Related Fraud**

- A construction company and its owner, contracted to perform construction work on a VAMC, were debarred from performing work with the Federal Government until January 2002. A VA OIG investigation disclosed evidence of poor workmanship, poor project management, and failure to complete projects on time, as found when the company failed to meet construction deadlines for a new tuberculosis ward at the VAMC. It also failed to pay sub-contractors and suppliers on time, failed to pay the prevailing wage rate, improperly used escrow funds, did not comply with contract specifications, and violated safety regulations. The value of the VA contract was approximately \$1.4 million.
- An individual, employed by a company that subcontracted on \$7.8 million in Government contracts to perform plumbing work on more than 20 projects funded by VA and the U.S. Department of Housing and Urban Development, pleaded guilty to one count of conspiracy to submit false statements. He and three others involved in the scheme, representing two separate companies, previously were indicted after a joint VA OIG and DOL OIG investigation revealed their involvement in a scheme to submit false wage and hour statements to VA for payment, and false payroll certifications to the DOL, indicating employees



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were being paid the prevailing union wage rate. Their participation in the scheme resulted in the two companies receiving approximately \$700,000 in additional Government payments to which they were not entitled.

### Procurement Fraud

- The president of a company that contracted to sell adaptive equipment vans to companies and handicapped veterans pleaded guilty in state court to four counts of grand larceny. A VA OIG investigation determined that the company was only leasing the vehicles and never held title to them. Once the company “sold” the vans to veterans, they stopped making the lease payments and as a result, collection agencies began threatening to confiscate vans that veterans believed they owned. The president of the company previously had been indicted on 24 counts of larceny, forgery, and false statements. Sentencing is pending.

- A criminal complaint and arrest warrant were issued for the owner and operator of a contracting company after a joint investigation revealed that the individual, doing business through the contracting company, engaged in fraud against VA and a host of other Federal agencies. The individual was subsequently arrested by special agents of the VA OIG, the Defense Criminal Investigative Service (DCIS), and U.S. Postal Inspection Service. Investigation disclosed that the individual illegally obtained Small Business Administration 8(a) set aside contracts and then defaulted on the work after securing substantial progress payments. He also allegedly submitted false bids and performance bonds on 16 Government contracts valued at approximately \$10 million. A VAMC contracted with the individual’s company for a replacement telephone system valued at more than \$5 million. This contract was terminated in August 1996, after the individual notified VA that, due

to severe financial and administrative problems, he would default the contract to his bonding company for completion. He had received more than \$900,000 in progress payments prior to default.

- A former manager of a firm contracting with the Government was sentenced to 3 years’ probation. Previously, the individual pleaded guilty to mail fraud and the company he represented settled a false claims civil suit by agreeing to pay the Government \$6 million. A joint VA OIG and General Services Administration OIG investigation disclosed that the company had failed to provide accurate cost or pricing information to the Government and did not pass on price reductions in connection with a multiple award contract. The individual submitted to the Government a false and forged letter as proof that the Government was receiving prices they were entitled to when, in fact, they were not.

- Two individuals were sentenced after a joint VA OIG and DCIS investigation disclosed that they accepted cash and goods from a VA contractor in exchange for placing orders for hand and power tools with his companies. The first individual was sentenced to 6 months’ home confinement, 200 hours’ community service, 5 years’ probation, and an \$8,000 fine after he pleaded guilty to conspiracy to accept bribes from the contractor. He admitted to accepting cash and machinery in exchange for placing 18 orders with the contractor’s companies totaling \$194,000. The second individual, a plumbing engineer and union president at a VAMC, was sentenced to 3 years’ probation and fined \$500 after pleading guilty to charges of supplementation of his salary as a public official. He admitted approving three orders to purchase approximately \$5,200 worth of hand and power tools from the contractor. This second individual voluntarily came forward with a confession after attending a Fraud and Integrity Awareness briefing sponsored by the

VA OIG. Additionally, an individual formerly employed as a tool and parts attendant at the VAMC was sentenced to 5 years' probation after pleading guilty to a charge of conspiracy to accept bribes from the contractor. He admitted accepting cash and goods in exchange for approving 25 orders to purchase \$18,000 worth of hand and machine tools and hardware from the contractor's companies. He was subsequently debarred from doing any Government contract work until January 2002. The contractor and his wife previously pleaded guilty to conspiracy charges and were implicated in plots to defraud the Departments of Defense and VA of \$400,000 and to provide substandard parts to the Government.

- An individual formerly employed as the vice president of sales in a medical products company pleaded guilty to a one-count criminal information charging him with conspiracy. A joint investigation by VA OIG, Department of Health and Human Services OIG, DCIS, and FBI disclosed that the scheme 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 that the laboratory charged VA for services not performed and for instances of unnecessary testing. Investigation is continuing.

### Bid Rigging

A company pleaded guilty to a one-count criminal information charging Conspiracy to Restrain Trade (Bid Rigging). A VA OIG investigation disclosed that the company conspired with other companies to violate the Sherman Antitrust Act in the award and performance of contracts to supply bread products to state school districts and to VA. As

a result of the investigation and plea, the bakery was fined \$500,000.

### **Product Substitution**

Three former executives of a company that distributed surgical instruments to the Government each pleaded guilty to smuggling goods into the U.S. and importation of goods by fraudulent means. The pleas were in response to a joint VA OIG, U.S. Customs, and Food and Drug Administration investigation which disclosed that the individuals imported surgical instruments from Pakistan, concealing the fact that Pakistan was the country of origin by first shipping the items through countries in Europe, where they were repackaged to give the appearance they were manufactured in those countries. The contract under which the items were purchased by the Government specifically named Pakistan as a prohibited source. As a result, the company bought surgical instruments of inferior quality at lower prices and then sold them at a premium rate to VA and other Government agencies. Losses to VA are estimated to be \$245,000. Sentencing dates have not been set.

### **Other Criminal Activity**

- An individual was indicted on third degree sodomy charges after a VA OIG investigation disclosed that he subjected another person to deviant sexual behavior without that person's consent while on VAMC property. The victim is a mentally impaired person who performed volunteer work in a nursing home located at a VAMC.
- An individual was arrested and subsequently indicted on one count of credit card fraud and one count of conspiracy to commit credit card fraud, in connection with his fraudulent use of a U.S. Government travel credit card which resulted in the theft of over \$95,000. The

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indictment was the result of a joint VA OIG and U.S. Secret Service investigation which disclosed that the individual intercepted a Government Visa card issued by Citibank intended for a former VAMC employee, and subsequently withdrew more than \$95,000 from multiple automated teller machines. The theft occurred in a short period of time during the transition to Visa from American Express. If found guilty, he faces up to 10 years' imprisonment and fines of up to \$250,000. The investigation is continuing.

## 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. 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

#### Loan Origination Fraud

- A husband and wife were charged in a 29-count indictment with conspiracy, making false statements on a Federal credit union loan application, and use of a false Social Security

number. Fraud involving VA surfaced during a U.S. Secret Service investigation of the couple alleging that they provided false information on credit applications. Further investigation by VA OIG disclosed that both the husband and wife provided an array of false information concerning employment and earnings when they obtained a VA-guaranteed mortgage on a property.

- A VA property management broker was sentenced to 12 months' probation and ordered to pay restitution of \$3,400 to VA after pleading guilty to charges of conspiracy to defraud VA. A VA OIG investigation disclosed that the individual assisted a buyer of a VA property in submitting false loan origination documentation to show that the buyer had more income than he actually had, in order to be able to qualify for the loan. In addition, the property management broker furnished half the down payment on the property, for a full 50 percent interest. As part of the plea agreement, the individual resigned her employment.

### Beneficiary Fraud

#### Employee Misconduct

- A former VA ratings specialist pleaded guilty to one count of theft of Government funds. A VA OIG investigation disclosed that the individual created a record of a fictitious veteran in August 1986 and proceeded to award the fictitious veteran benefits for service connected disabilities. He then had over \$624,000 in monthly benefits deposited into a savings account opened in the name of the fictitious veteran and every month, would withdraw funds from the account. In August 1998, the individual was arrested by VA OIG special agents while making a withdrawal from the account in the fictitious veteran's name. At the time of arrest, he was in possession of

\$10,000 and was wearing a set of green army fatigues over his clothes in order to disguise his appearance. Sentencing is pending.

- A former VARO supervisor pleaded guilty to a criminal information charging her with engaging in money laundering and other offenses. She had earlier resigned her position at the VARO after being arrested on charges of making false claims to the Government and theft of Government funds. A joint task force investigation comprised of members from VA OIG, U.S. Postal Inspection Service, and the FBI disclosed that the employee created computerized records which fraudulently reflected that her fiancé was a 100 percent service-connected disabled veteran. She then caused VA to issue checks and make direct-deposit payments totaling more than \$600,000 into a bank account she had opened in both their names. The VARO was in the process of suspending the employee pending termination when she resigned from her position. Sentencing is pending.

- A former VA Medical and Regional Office Center claims examiner was convicted on charges of making false claims to the Government and subsequently sentenced to 6 months' imprisonment, 3 years' probation and fined \$1,000. A VA OIG investigation disclosed that the individual, who was also a veteran, knowingly claimed an ineligible individual as a dependent on his application for veteran's compensation benefits, in order to receive additional funds to which he was not entitled.

### Compensation Benefits Fraud

- A U.S. Marine, who faked his death to receive the proceeds from military life insurance, VA and Social Security Administration (SSA) benefits, was officially charged by the U.S. Marine Corps with multiple violations of the Uniform Code of Military Justice and will face court martial later this year.

Among the charges are desertion, assault with a deadly weapon, assault, impeding an investigation and multiple counts of sexual assault, sodomy and rape of children. The individual and several of his relatives face separate charges for theft of Government funds and conspiracy regarding the wrongful receipt of insurance, VA, and SSA benefits. The individual also faces charges of murder and arson in state court relative to the circumstances surrounding his faked death. He has already been convicted on separate charges of sexual assault and was sentenced for that conviction to 45 years in jail. This is a joint VA OIG and SSA OIG investigation.

- An individual was indicted for making false statements to VA in order to continue receiving VA Dependency and Indemnity Compensation (DIC) benefits. A VA OIG investigation disclosed that the individual, the surviving widow of a deceased veteran, remarried in 1970 and failed to inform VA of her marriage. Prior to the marriage, she was entitled to receive DIC benefits as the surviving spouse; however, entitlement terminated when she remarried. She failed to report the marriage and took steps to conceal that information from VA, causing benefits totaling more than \$130,000 to be disbursed.

- A VA OIG investigation determined that, for almost 16 years, an individual, who falsely certified to VA that he was unemployed in order to receive benefits, actually worked continuously as a full-time fire alarm operator. The individual's false claims resulted in his collecting almost \$112,000 in VA compensation benefits, based on unemployability, to which he was not entitled. The matter could not be prosecuted criminally due to the expiration of the statute of limitations; however, the results of the investigation have been reported to the VARO, and collection action has begun.

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- An individual pleaded guilty to one count of fraudulent acceptance of VA benefits. A VA OIG investigation disclosed that the individual failed to report her mother's death and, for 9½ years, diverted and negotiated her deceased mother's DIC benefits. Total loss to VA is approximately \$57,000.
- An individual was arrested on charges of theft of Government funds after a VA OIG investigation revealed that the individual has diverted more than \$49,000 in VA DIC and Civil Service Retirement Annuity benefits intended for her mother. The individual failed to report her mother's death in 1991, which would have caused the payments to cease. The investigation continues, and a trial date is pending.
- An individual was arrested by VA OIG and SSA OIG special agents as a result of a sealed indictment charging him with 10 counts of uttering a forged writing and 1 count of making a false statement. The indictment charged that over a 7-year period, the individual forged and negotiated U.S. Treasury checks representing VA DIC benefits and social security benefits intended for his deceased mother. The total loss to the Government exceeds \$80,000.
- An individual was sentenced to 4 months' home detention, 3 years' supervised probation, and was ordered to pay \$97,685 in restitution in response to a prior guilty plea to charges of theft of Government funds. A VA OIG investigation disclosed that the individual, failing to notify VA of her mother's death, cashed DIC benefits checks totaling \$97,685 issued to the deceased mother.
- A husband and wife were sentenced for the theft of VA benefit checks after pleading guilty to charges that they fraudulently diverted VA benefits intended for the husband's mother. The husband was sentenced to 5 years' probation, 3 months in a halfway house, 4 months' home confinement, and ordered to pay \$73,648 in restitution. The wife was sentenced to 5 years' probation, 6 months' home confinement, and joint responsibility with her husband for restitution. A VA OIG investigation disclosed that the couple failed to report the mother's death in April 1987, and continued for 9½ years to accept and negotiate her VA DIC benefits checks totaling \$73,648.
- Two individuals, a husband and wife, were indicted and charged with seven counts of false contracts, deeds, and powers of attorney and one count of conspiracy. The couple conspired to forge and negotiate U.S. Treasury checks representing DIC benefits intended for the wife's deceased mother. The total loss to the Government is estimated at \$46,782.
- An individual pleaded guilty to theft of Government property and was subsequently sentenced to 10 months' home detention, 5 years' probation, and was ordered to pay \$65,600 in restitution after pleading guilty to one count of theft of Government property. The individual previously had been indicted on 51 counts of theft of Government property and making false statements. A VA OIG investigation disclosed that, for a period of almost 6 years, the individual continued to receive and negotiate his deceased mother's VA DIC payments, which should have ceased at the time of her death.
- A husband and wife each were sentenced to 6 months' home detention with electronic monitoring, 3 years' probation, and ordered to pay total restitution of \$48,095 to VA. The couple previously had pleaded guilty to one count each of theft of Government funds. A VA OIG investigation disclosed that, for almost 9 years, the couple received and negotiated more than \$48,000 in VA DIC benefits checks payable to the wife's deceased mother.

- An individual pleaded guilty after being indicted and charged with making false statements to the Government when an investigation disclosed that she used a false name and Social Security number to divert more than \$26,000 in DIC benefits to which she was not entitled. A joint VA OIG and SSA OIG investigation revealed that the individual, the widow of a deceased veteran, had been in receipt of DIC benefits since 1977. She also had been in receipt of Social Security benefits for part of that time period, but failed to disclose the receipt of the additional benefits to VA.

### Pension Benefits Fraud

- An individual was indicted by a Federal grand jury and charged with filing false statements. The indictment is the result of a VA OIG investigation that determined the individual made false statements regarding his total family income which caused VA to pay him \$54,000 in benefits to which he was not entitled.
- The spouse of a deceased veteran was indicted on charges of theft of Government property for continuing to collect benefits and failing to report the veteran's death. A joint VA OIG, Railroad Retirement Board (RRB), and U.S. Secret Service investigation disclosed that the wife continued a scheme initiated by the veteran before his death whereby, using a false name, fraudulent Social Security number and date of birth, he created a false identity and lived under the assumed name. Under his actual name, he received VA and RRB benefits. Upon his death, he was buried under the false identity; therefore, VA and RRB benefits continued. The wife further perpetrated the fraud by having her sons forge the veteran's name on yearly verification forms, which she continued to file with both VA and the RRB after his death. Loss to VA is approximately \$51,000.
- As the result of a joint VA OIG and U.S. Postal Inspection Service investigation, the brother of a deceased veteran was sentenced to 24 months' imprisonment, 36 months' probation, and ordered to pay \$40,000 in restitution for crimes associated with impersonating his twin brother to illegally obtaining VA benefits. After the death of the veteran, the brother assumed the veteran's identity and continued to receive and cash VA pension checks, making at least five changes of address to which the checks were mailed. The veteran's brother also obtained a VA guaranteed home loan for his daughter by claiming to be the veteran and filing false documentation with the mortgage company and VA. The fraudulently obtained loan has defaulted. Potential loss to VA is in excess of \$70,000.
- An individual who fraudulently claimed to be a Navy veteran in order to get VA pension and health benefits was sentenced to 6 months' home detention, 2 years' probation, and was ordered to make efforts to repay \$41,961 in pension benefits and \$9,748 in medical services he improperly received. He had pleaded guilty in an earlier court appearance to theft of Government funds. He received a reduced sentence in response to a motion filed by his attorney, which showed he is presently suffering from debilitating ailments including heart and kidney failure and diabetes. His older brother had fraudulently enlisted in the Navy years ago using his identity. After receiving VA correspondence with his name on it, he applied for benefits. The older brother was not prosecuted for his fraudulent enlistment as the statute of limitations had expired.
- An individual was sentenced to 4 months' imprisonment, 4 months' home confinement and was ordered to pay \$50,571 in restitution after pleading guilty to making false statements to obtain VA pension benefits. A VA OIG investigation disclosed that the individual remarried twice following her veteran husband's

## Office of Investigations

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death and failed to notify VA of either marriage. VA pension benefits are provided to the surviving spouse and children of a deceased veteran and are terminated when the spouse remarries. Loss to VA is more than \$50,000.

### Fiduciary Fraud

- An individual acting as a VA fiduciary, court-appointed guardian, and Social Security representative payee to a number of elderly veterans pleaded guilty to mail fraud and misapplication of funds by a VA fiduciary. The individual wrongfully appropriated more than \$200,000 in funds belonging to the estates of six of her elderly, veteran wards, five of whom were judged to be mentally incompetent. She also made a series of false and fraudulent statements on accountings that were submitted to VA in order to conceal the thefts.

- An attorney was arrested pursuant to a nine-count indictment and subsequently pleaded guilty to one count of mail fraud in connection with the theft of approximately \$120,000 from the guardianship account of a disabled World War II veteran. The individual acted as court-appointed guardian for the veteran from 1989 to 1994, during which time he was entrusted to receive Government benefits and other monies due to the veteran, and was required to submit periodic reports to the court and VA concerning his handling of the veteran's finances. A VA OIG investigation disclosed that in 1993, the individual started withdrawing large amounts of money from the veteran's account to pay for his personal expenditures.

- A plea agreement and criminal information were filed charging an individual with misappropriation by fiduciary. A joint VA OIG and SSA investigation disclosed that the individual, over a 1-year period, embezzled approximately \$104,000 from three incompetent veterans while serving in a fiduciary capacity.

- An individual appointed to act as fiduciary for his cousin, a veteran judged by VA to be unable to handle his VA benefit funds, pleaded guilty to seven counts of theft of Government funds for stealing the cousin's VA benefit monies. A VA OIG investigation disclosed that, over a period of approximately 3 months, the fiduciary forged VA authorization letters and illegally drained the funds from a restricted bank account. The veteran never received any of the funds withdrawn from the account. The unauthorized withdrawals by the fiduciary amounted to a theft of almost \$39,000 in VA compensation benefits.

- An individual pleaded guilty to a one-count criminal information charging him with fraudulently misusing VA compensation benefits belonging to an incompetent veteran. A VA OIG investigation disclosed that the individual, who was serving as fiduciary for his brother, a veteran deemed to be incompetent to take care of his own affairs, failed to account for expenditures of VA funds in excess of \$10,000 over a period of 14 months. He admitted to misappropriating the veteran's benefits for his personal use.

### Educational Benefits Fraud

- The civil division of the U.S. Attorney's Office is continuing to obtain civil settlements from student veterans who received VA benefits but did not attend regularly scheduled classes at a community college. Bribes were paid to faculty staff including the chairman of a department at the college to ensure that high grades would be given with no class attendance required. Most recently, the civil division has obtained settlement agreements from additional students. The total number of students who have negotiated settlement agreements thus far with the civil division is 241, resulting in restitution totaling \$2,834,913. Civil actions have been filed against student veterans who declined to negotiate settlement agreements, and there are

109 remaining cases pending resolution. A trial date is pending as a result of indictments against the college staff.

### Vocational Rehabilitation and Counseling Service

A former VA contractor who owned a computer company pleaded guilty to a one-count criminal information charging him with filing fraudulent claims with VA for products that were never delivered. A joint VA OIG and FBI investigation of fraud by fee-basis providers and others associated with VA's Vocational Rehabilitation & Counseling Service program disclosed that the company owner and another individual conspired to defraud VA by submitting invoices for approximately \$67,838 in computer equipment that was never delivered. Investigation further revealed that a network of Government contractors, hired to provide various services such as training and case management services to disabled veterans in vocational rehabilitation, conspired to bill VA for remedial educational, employment and vocational training services which, in many instances, were not provided. An additional plea relating to this matter is anticipated.

## **National Cemetery Administration**

### **Employee Misconduct**

- An individual employed as a caretaker at a VA national cemetery pleaded guilty to charges of witness tampering. An accomplice, employed as a foreman at the cemetery, earlier pleaded guilty to related charges of bribery. A VA OIG investigation disclosed that the foreman solicited and accepted bribe money from a probationer

who was assigned by a state court to perform community service at the cemetery. The probationer's time and attendance record was falsified by the foreman to reflect over 200 hours of service not actually performed. Both employees attempted on numerous occasions to prevent witness cooperation with the investigating agents, once the nature of the investigation became known. Sentencing for both is pending.

- An individual resigned as a VA program assistant after being confronted by investigators with evidence of her misuse of two Visa SmartPay cards. A joint VA OIG and FBI investigation determined the employee illegally used two Visa cards assigned to her, for support of administration operations, to purchase over \$284,000 in computers and electronic entertainment equipment, which she converted to personal use or resold for 50 percent of market value for personal gain. She also used the cards to cover some personal expenses. Criminal charges are pending.

## **Office of Human Resources and Administration**

### **Support to VA Central Office**

#### Theft and Embezzlement

Two VA laborers resigned their positions after being notified that they would be terminated from employment for their roles in the theft of VA property. A third individual employed as a VA supply technician executed a 1-year "last chance agreement" and accepted a 30-day suspension in connection with his lesser involvement in the property thefts. All three



## Office of Investigations

employees, who were implicated in the theft and attempted theft of \$9,750 in VA property, surfaced during a joint VA OIG and VA Office of Security and Law Enforcement investigation into extensive VA property thefts. Other employees who were found to be involved more extensively in the thefts of over \$40,000 in property were prosecuted previously and have been sentenced.

### OIG Forensic Document Laboratory

The OIG operates a nationwide Forensic Document Laboratory service for fraud detection that can be utilized by all elements of VA. The types of requests routinely submitted to the laboratory include handwriting analysis, typewriting, inks, paper, photocopied documents, and suspected alterations of official documents. During this reporting period, the laboratory received 288 documents from various non-OIG sources and 1,642 pieces of evidence in 8 OIG investigations, which required extensive laboratory examinations. A review and inspection of the laboratory concluded that laboratory examinations conducted for the Department on questioned documents submitted in support of benefits claims resulted in savings of approximately \$248,000 over the past 2 years. There were a total of 32 forensic laboratory reports issued during this semiannual period.

<b>Laboratory Cases for the Period</b>	
<b>Requester</b>	<b>Cases Completed</b>
OIG Office of Investigations	8
VA Regional Offices	17
Board of Veterans Appeals	4
VA Office of Regional Counsel	2
Finance & Administration Service	1
<b>TOTAL</b>	<b>32</b>

The following are examples of laboratory work that was completed:

- VA OIG investigated a registered nurse practitioner who diverted drugs from a VA domiciliary for her own use. The nurse wrote bogus prescriptions for a veteran who was not a patient, and wrote other bogus prescriptions for patients at the domiciliary. The laboratory examinations identified the registered nurse practitioner as the author of handwritten entries on 11 bogus prescriptions. An indictment is anticipated in this case.
- VA OIG investigated a former health system specialist at a VA medical center, and two non-VA associates who used the confidential identifying information of at least three VA employees to apply fraudulently for various credit card accounts. The amount of fraud exceeds \$60,000, and involves at least 17 accounts. Laboratory examinations identified one subject of the investigation as the author of the forged signatures of the three VA employees. The same subject also was identified as the author of handwritten entries appearing on documentary evidence associated with the credit card fraud schemes. An indictment is anticipated in this case.

- VA OIG investigated a foreman employed at a VA national cemetery who solicited and accepted bribes from a probationer. The VA cemetery hosts individuals placed on probation by the local State District Court to perform court ordered community service at the cemetery. The VA foreman accepted money from one probationer in order to complete sign-in sheets that falsely showed he worked over 200 hours at the cemetery. Laboratory examinations identified the VA foreman as the author of fraudulent entries appearing on the sign-in sheets. The VA foreman pleaded guilty to bribery.
- VA OIG investigated an individual who assisted a widow of a 100 percent service connected veteran to obtain DIC benefits. The widow did not speak or understand English. Laboratory examinations identified the subject as the author of the widow's signatures on U.S. Treasury checks, one of which was for \$32,952. The subject also was identified as the author of 41 fraudulent handwritten entries related to VA benefit payments to the widow.

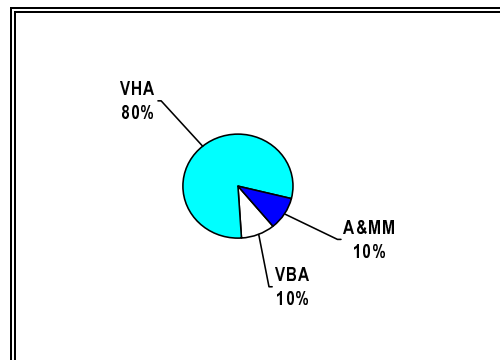
## II. ADMINISTRATIVE INVESTIGATIONS DIVISION

### 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 22 cases, 6 of which had Congressional interest.

### Output

- During the reporting period, 10 reports and 1 administrative letter were issued. Twelve cases resulted in administrative closures.

## Office of Investigations

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### Outcome

- VA managers took administrative actions against 18 high-ranking officials and other employees and 13 corrective actions to improve operations and activities as the result of these reviews.

### Customer Satisfaction

- Customer satisfaction surveys indicated that VA managers found reports to be useful in addressing allegations at their facilities. The customer satisfaction survey rating for the period averaged 4.1 out of a maximum of 5 possible points.

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

### Misuse of Position and Waste of Resources

An administrative investigation substantiated that a senior official improperly requested and approved construction of a \$5,000 fence at the Government quarters he occupied, in part to accommodate his pet. We concluded the official misused his position to benefit himself. The investigation also disclosed that a senior official wasted medical care funds to construct a canoe ramp on VA property that was not for patient use, and that he leased a large passenger sedan without determining whether it was mission-essential. VHA officials informed us they planned to take administrative action against the

official. VHA also took administrative action against the senior official, billed the other official for the cost of the fence, and returned the large sedan. (*Conduct Issues Concerning a Senior Official, Alvin C. York VA Medical Center, Murfreesboro, Tennessee, 9PR-D03-026, February 2, 1999*)

### Harassment

An administrative investigation substantiated that a senior official inappropriately removed a document from a private automobile. The investigation disclosed that the senior official reached into the automobile to remove a document the official reasonably believed might be released to the media in violation of the Privacy Act. We concluded that, while we understood the motivation, the action had the effect of harassing three employees. VHA officials informed us they would take appropriate administrative action against the senior official. (*Conduct and Personal Property Issues, New Jersey Health Care System, Lyons Division, New Jersey, 9PR-G03-035, February 12, 1999*)

### Misuse of Position

An administrative investigation substantiated that a senior official of a VAMC misused the position to receive free medical care improperly. The investigation disclosed that, for a 2 – 3 year period, the senior official asked a subordinate employee for monitoring and treatment of a medical condition, rather than seeking treatment from a private physician. VHA officials informed us they took appropriate administrative action against the official and discussed the proper use of healthcare services with the physicians involved. (*Ethical Conduct Issues, VAMC Memphis, Tennessee, 9PR-A03-015, January 20, 1999*)

## **Gambling and Time and Attendance Issues**

An administrative investigation substantiated that a supervisory employee used poor judgment in granting administrative leave to her subordinates to attend monthly social activities, particularly when the activities occurred at a gambling casino. The investigation also substantiated that a senior official used poor judgment by allowing the employees to go off-station routinely for periods in excess of that prescribed by VA's regulations. Further, the investigation disclosed that management controls over time and attendance activities in another area of the facility were lax. VHA officials took appropriate administrative and corrective actions to address these issues. (*Gambling, Time and Attendance, and Other Issues, VAMC Biloxi, Mississippi, 9PR-A99-043, March 3, 1999*)

## **Travel, Vehicle Use, and Contracting Issues**

An administrative investigation substantiated that a VISN senior official misused a Government vehicle, established an unnecessary office away from his official duty station, and performed unnecessary temporary duty travel there to be near his family residence. The investigation also substantiated that the official improperly claimed and received reimbursement from another Government agency when he drove a VA Government vehicle on temporary duty travel. Further, the investigation disclosed that the official unnecessarily selected a large luxury sedan for his use, contributed to irregularities in the procurement of consulting contracts, and wasted funds by locating a VISN position outside the geographic boundaries of the VISN. The investigation substantiated that another senior VISN official also misused a Government vehicle. The VISN subject of the complaint resigned before the report was

finalized, which precluded administrative action being taken. VHA officials informed us they would take appropriate administrative action against the other senior VISN official and responsible procurement officials, and had taken, or would take, other corrective actions. (*Travel, Vehicle Use, and Contracting Issues, Mid-Atlantic Veterans Integrated Service Network, Durham, North Carolina, 9PR-A99-059, March 25, 1999*)

## **Misuse of Position and Misuse of Resources**

An administrative investigation substantiated that a VA physician misused his position when he solicited funds for a private venture using VA letterhead and the VA facility's name, and improperly solicited donations from companies doing business with VA. The investigation also substantiated that a senior official improperly disposed of medical supplies by donating them to the physician for his private venture. Finally, the investigation disclosed that three employees, who were not veterans, improperly received treatment by the medical center's medical staff. VHA officials informed us appropriate administrative action would be taken against the physician who misused his position, the senior official who improperly disposed of medical supplies, and the employees who received medical treatment improperly. VHA officials also informed us the employees who should not have received treatment were billed for their medical procedures. (*Misuse of Position and Misuse of Resources Issues, VA Palo Alto Health Care System, Palo Alto Division, California, 9PR-A19-045, March 16, 1999*)

## **Use of Credit Union Checking Account**

An administrative investigation substantiated that the VA Central Office Chaplain Service improperly maintained a credit union checking account after March 1990 despite directives to the contrary. The investigation found no evidence that Chaplain Service officials improperly spent appropriated funds deposited in the account, although they improperly commingled those funds with other, non-appropriated funds. The investigation concluded that using appropriated funds to pay for meals at the Service's annual conference was proper as long as participants adjusted their claims for per diem reimbursement. Chaplain Service officials informed us they would close the account and consult with the Office of General Counsel to determine the proper disposition of the account's balance. (*Credit Union Checking Account Issues, VA Central Office Chaplain Service, Hampton, Virginia, 9PR-A18-073, March 30, 1999*)

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# OFFICE OF AUDIT

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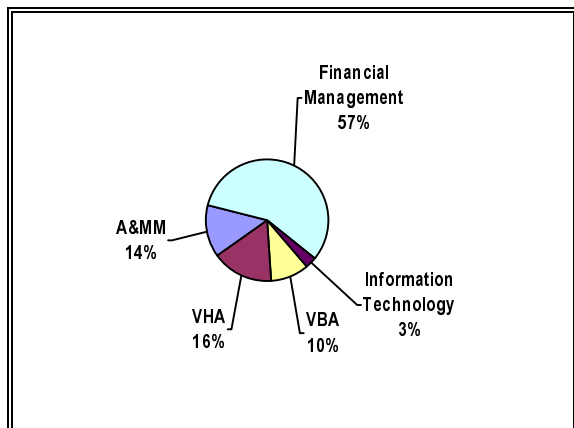
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## Mission Statement

*Improve the management of VA programs and activities by providing our customers with timely, balanced, credible, and independent financial and performance 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 prices paid.*

## Resources

The Office of Audit had 154 FTE assigned in VA Central Office and 7 operating divisions throughout the country. 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 reimbursed by the VA Office of Acquisition and Materiel Management. This Division conducts

preaward and postaward reviews of certain categories of VA contracts.

## Overall Performance

### Output

- Issued 24 performance and financial audits and evaluations, for an output efficiency of one report per 6.4 FTE; and issued 19 contract review reports (6 preaward contract reviews and 13 postaward reviews), for an output efficiency of one report per 1.2 FTE.

### Outcome

- Recommendations were made to enhance operations and correct operating deficiencies with monetary benefits totaling \$426 million. In addition, postaward contract reviews identified recoveries of \$8.6 million and preaward contract reviews, designed to assist VA contracting officers in negotiating the best possible prices, made recommendations that could save VA \$23.9 million.

### Cost Effectiveness

- A return of \$57 in monetary benefits was achieved for every dollar spent in performance and financial audits and evaluations, \$10 was recovered for every dollar spent on postaward contract reviews, and \$63 in contract costs were avoided for every dollar spent on preaward contract reviews.

### Customer Satisfaction

- Customer satisfaction with performance and financial audits and evaluations was 4.3 on a scale of 5, for reports issued during the period. The average customer satisfaction rating for contract reviews was 4.4 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, and issues requiring action by multiple offices.

## Veterans Health Administration

### Resource Utilization

**Issue: Implementation of VHA's overall reorganization plan in VISN 10.**

**Conclusion: Integration of VISN 10 facility management structure is proceeding as planned. However, some improvement is needed.**

**Impact: Improved quality of care and better use of funds.**

The audit assessed the Veterans Healthcare System of Ohio's (also known organizationally as VISN 10) implementation of VHA's overall reorganization plan, and examined implementation of three of VHA's most significant strategic goals and objectives. The audit found the Network is effectively implementing the Under Secretary for Health's reorganization plan. We also found the Network's efforts to reduce costs per patient treated have been substantial and the Network has a number of initiatives in process to increase medical care funding from sources other than Federal appropriations. Network efforts to increase veteran access to VA healthcare are also proving effective. However, we found Network management needs to take action to ensure that weaknesses in VHA processes relating to patient enrollment, reporting, and resource allocation do not adversely affect these efforts. We found the patient enrollment process

did not include all eligible veterans who had applied for care at the Network's facilities. Also, patient workload was not properly accounted for by the Veterans Equitable Resource Allocation funding model. The Network Director concurred with the report recommendations and provided appropriate implementation actions. (*Audit of VISN 10 Organization, Planning, and Implementation of Key Strategic Goals and Objectives, 9D2-A19-001, 1/12/99*)

**Issue: Decision Support System (DSS)**

**Conclusion: VHA must adhere to the basic building-block structure if the system is to achieve its full potential.**

**Impact: Better use of invested funds.**

We audited VHA's implementation of a new management information system intended to aid clinicians, managers, and executives in making decisions affecting the delivery of health care. The audit was requested by the Under Secretary for Health, and its purpose was to determine if implementation of DSS at 147 medical facilities was sufficiently standardized to ensure the usefulness of DSS data at local, VISN, and VHA headquarters levels. Through September 1998, we estimate that implementation of DSS cost about \$140 million. The potential usefulness of DSS and its data was being compromised because some medical center staff had diverged from the system's basic structural standard. Where such divergence had been detected, it prevented data from these medical centers being accurately aggregated along with data from other facilities that did adhere to the standard. We were also concerned that data divergences that had not been detected may have resulted in inaccurate data being aggregated into roll-up reports. Facilities that had diverged from the DSS structural standard also lost the opportunity to perform a variety of analyses that adhering to the structural standard provides.

For DSS to achieve its full potential, we recommended that the Under Secretary for Health: (i) ensure that all staff and managers involved with DSS be required to input data into the local DSS systems in adherence with the standard DSS structure, (ii) periodically determine the degree of adherence to the DSS structural model that is required of medical center systems, and (iii) establish the controls necessary for full compliance with decisions made under (ii). The Under Secretary for Health concurred with all report findings and recommendations, and provided acceptable implementation plans. Therefore, all issues in the report are considered resolved. (*Audit of VHA Decision Support System Standardization, 9R4-A19-075, 3/31/99*)

**Issue: Clinical services contracts with medical schools.**

**Conclusion: VAMCs need additional guidance on using commercial contracts to purchase services.**

**Impact: Reduce risk associated with noncompetitive contracts to purchase services.**

We performed an evaluation of VAMC practices in contracting for clinical services with affiliated medical schools. The evaluation focused on determining if VAMCs were using inappropriate contracting practices, such as using Intergovernmental Personnel Act assignments (IPAs) as a substitute for scarce medical specialist (SMS) contracts. That practice was identified in a 1997 audit of IPAs. As a result of findings from the 1997 audit, VHA issued guidance directing VAMCs not to use IPAs to obtain clinical services. We followed up on the implementation of that guidance in the current audit.

We found that some VAMCs continued to use IPAs as a substitute for SMS contracts. We reviewed 25 non-research IPAs at 4 VAMCs and found that all 25 were an inappropriate use of

the IPA authority. Of the 25 IPAs, 18 (72 percent) were established after the issuance of the VHA guidance on IPAs. In response to our finding, VHA management initiated immediate corrective action, issuing a memorandum that forcefully directed VAMCs to terminate inappropriate IPAs.

The evaluation also found that some VAMCs had begun using commercial item contracts as a substitute for SMS contracts. Unlike SMS contracts, commercial item contracts do not require cost or pricing data to support proposed prices. As a consequence, there is a risk that VAMCs could overpay for services. We recommended that VHA follow through with issuing guidance that would: (i) emphasize the importance of obtaining sufficient information to insure that prices paid on noncompetitive commercial item contracts are reasonable, and (ii) recommend the use of cost or pricing data as the benchmark for price reasonableness for staff-based contracts and Medicare rates as the benchmark for procedure-based contracts. The Under Secretary for Health concurred in principle with the recommendation and provided an acceptable implementation plan. (*Evaluation of VAMC Clinical Services Contracts with Medical Schools, 9R8-E11-008, 10/30/98*)

**Issue: Medical center investment in ambulatory care infrastructure.**

**Conclusion: Significant efforts were made to reduce inpatient infrastructure and increase ambulatory care infrastructure, but data was not adequate to identify and quantify the sources of funding.**

**Impact: Improved resource allocation.**

At the request of the Under Secretary for Health, the OIG conducted an evaluation to determine whether savings resulting from reductions in inpatient care infrastructure were reinvested in ambulatory care infrastructure. Additionally, the Under Secretary requested our suggestions for



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improving the collection of cost data and cost reporting systems.

Our evaluation found that, for the 5 facilities reviewed during the period FYs 1994 through 1998, inpatient workload fell 64 percent, 44 percent of operating beds were closed, inpatient staffing was reduced 28 percent, and outpatient workload increased 46 percent. Additionally, significant investment in campus and community based ambulatory care infrastructure took place at each medical center visited.

Regarding the utility of VHA cost information systems, we concluded that: (i) VHA's cost accounting system, the Cost Distribution Report (CDR), was not sufficiently reliable to quantify the reinvestment of inpatient infrastructure savings in ambulatory care infrastructure, and (ii) the Decision Support System, VHA's planned successor cost accounting system to the CDR, has the potential to provide more useful and reliable data on the cost of providing services.

We suggested that management provide supplemental direction for collection and reporting of workload and cost data to the CDR, pending full implementation of DSS.

The Under Secretary for Health agreed with our conclusions. He stated that a work group has been established to develop an action plan for replacement of the CDR. He also indicated that further study would be conducted of the relational consistencies of inpatient and outpatient costs through time. All issues are considered resolved. (*Evaluation of Medical Center Investment in Ambulatory Care Infrastructure, 9AY-A19-061, 3/31/99*)

**"I appreciate your prompt and professional response to my request."**

**Under Secretary for Health**

**Issue: Income Verification Match (IVM).  
Conclusion: Improved procedures can prevent unnecessary verification, ensure compliance with the Privacy Act, and increase collections.  
Impact: Increase funding by \$14.2 million and better use of \$3.8 million.**

We conducted an evaluation of VHA's IVM program to: (i) follow-up on the implementation of recommendations made in a March 27, 1996 OIG report, *Review of VHA's Income Verification Match Program*, and (ii) determine whether there are opportunities for VHA to conduct the IVM program in a more efficient and cost effective manner.

We concluded that VHA can ensure compliance with Privacy Act requirements, increase funding available for health care by \$14.2 million, and put resources valued at \$3.8 million to better use, by requiring VISN Directors to establish performance monitors for means testing activities and billing and collection of program referrals. Additionally, to further ensure these monetary benefits are achieved, VHA management needs to implement previous recommendations and the Chief Information Officer needs to increase oversight of Health Eligibility Center (HEC) activities. VHA also needs to expedite action to centralize means testing activities at the HEC.

We recommended that VHA improve IVM program activities by: (i) requiring VHA's Chief Network Officer to ensure that VISN Directors establish performance standards and quality monitors for means testing activities and billing and collection of program referrals, (ii) requiring the VHA Chief Information Officer to develop performance measures and monitor periodic performance reports of HEC activities, and (iii) expediting action to centralize means testing activities at the HEC.

The Under Secretary for Health concurred with the findings, recommendations, and estimated monetary benefits and provided acceptable implementation plans. (*Evaluation of VHA's Income Verification Match Program, 9R1-G01-054, 3/15/99*)

## Facility Management

**Issue: Ensuring that construction projects are justified and funds are used to meet agency goals.**

**Conclusion: Cost effective alternatives were available for some projects.**

**Impact: Better use of funds.**

We audited two construction projects as part of an ongoing national audit of Minor Construction and Nonrecurring Maintenance.

### Ambulatory Care Renovation Project at VAMC Atlanta, GA

We conducted the audit to determine whether this ambulatory care renovation project was necessary or whether there were alternatives that would satisfy the needs of the medical center in a more cost-effective manner. We concluded that the project should be reevaluated.

According to the project plans, a new 2-story addition would be built adjacent to the existing ambulatory care building to provide additional space for ambulatory care functions. The addition would add 12,500 net square feet and cost \$3.7 million.

Our audit found that the existing ambulatory care area was crowded and improvement was needed. However, medical center management did not adequately assess the impact that three other construction projects, which more than double existing ambulatory care space, will have on space needs. Also, they did not adequately

determine the effect that new Community Based Outpatient Clinics would have on reducing medical center workload and space needs.

We concluded that the \$3.7 million project was not adequately justified. We recommended that the project not be approved until space needs are reevaluated. The Director, VISN 7 concurred with the recommendations and began an acceptable implementation plan by conducting a reevaluation of space needs. While we consider the recommendations resolved, we reviewed the VISN 7 interim reevaluation results and concluded that the need for the project has not yet been demonstrated. We will follow up on these issues until implementation is completed. (*Audit of Ambulatory Care Renovation Project at VAMC Atlanta, GA, 9R5-D02-032, 1/29/99*)

### Surgical Suite Renovation Project at VAMC Fresno, CA

We conducted an audit of the renovation project to determine whether it was necessary or whether alternatives existed that would provide the required services in a more cost-effective manner. According to the project plans, the existing surgical suite comprised of four operating rooms would be remodeled to provide state-of-the-art equipment and utilities and adequate space for efficient traffic flow.

Our audit found the existing surgical suite was in need of modernization and the existing layout did not provide appropriate patient flow from the surgery preparation area to the recovery area. However, the current surgical workload did not support the need for four operating rooms. VAMC management believed that surgical workload will increase in the future, and estimated that the cost to remodel four operating rooms instead of three would not be significant. We agreed, but recommended that the fourth operating room not be equipped unless justified by future workload and that future projects be thoroughly assessed. This would enable

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\$126,000 in equipment funds to be redistributed for better use. The Director, VISN 21 agreed with our recommendation and provided acceptable implementation plans. (*Audit of Surgical Suite Renovation Project at VAMC Fresno, CA, 9R5-D02-007, 10/23/98*)

**“Your assistance in this important matter is appreciated.”**

**Director, VA Sierra Pacific Network**

Award Presentation  
[photo not available electronically]

## OIG Contribution Award

During the last year, the OIG has been engaged in a joint effort with VHA to review the Workers' Compensation Program (WCP). This effort included the development of a protocol package and handbook for use in day to day WCP case management and detection for program fraud. A review of the WCP area in VISN 22 was completed to test and refine the methodologies used in the protocol package.

Arlene B. Rubin, WCP Coordinator at VAMC Long Beach was presented an Inspector General's Contribution Award and a plaque for her outstanding contribution and assistance in this joint effort to enhance case management, reduce WCP costs, and detect fraudulent workers' compensation claims.

Pictured at the award ceremony are, from the left: James Farmer, OIG Project Manager; Sandra Miller, OIG Staff Auditor; award recipient Arlene B. Rubin, WCP Coordinator at VAMC Long Beach; Juanita Martinez, Equal Employee Opportunity Manager, VAMC Long Beach; Kathryn Goto, Associate Director, VAMC Long Beach; Melvin Reid, OIG Staff Auditor; and Stephen Gaskell, Director, OIG Central Office Operations Division.

## Veterans Benefits Administration

### Delivery of Benefits and Services

**Issue: Benefit payments to incarcerated veterans.**

**Conclusion: VBA did not implement a systematic approach to identify incarcerated veterans and dependents.**

**Impact: Past and future overpayments exceeding \$170 million.**

We conducted an evaluation to determine if benefit payments to incarcerated veterans were appropriately adjusted. The evaluation included veterans incarcerated or released from State prisons in California, Florida, Michigan, New York, Ohio, and Texas. The evaluation also included review of VARO processing of prisoners' data received from the Federal Bureau of Prisons.

We found that VBA officials did not implement a systematic approach to identify incarcerated veterans and dependents, and adjust their benefits as required by Public Law 96-385. A

prior audit conducted in 1986 found that controls were not in place to cutoff benefits to veterans when they were incarcerated. In that audit we recommended that a systematic approach be applied, but actions were not taken to implement the recommendations.

According to the Department of Justice, Bureau of Justice Statistics, Federal and State prison populations more than doubled since 1986, from 522,100 to 1,085,400. In addition, about 4.6 million individuals have been admitted to and about 4.1 million inmates have been released from Federal and State prisons since 1986.

The current evaluation included review of 527 veterans randomly sampled from the population of veterans incarcerated in 6 states. Results showed that VAROs had not adjusted benefits in over 72 percent of the cases requiring adjustment, resulting in overpayments totaling \$1.8 million. Projecting the sample results nationwide, we estimate that about 13,700 incarcerated veterans have been, or will be, overpaid about \$100 million. Additional overpayments totaling about \$70 million will be made over the next 4 years to newly incarcerated veterans and dependents, if VBA does not establish a systematic method to identify these prisoners.

We recommended that the Under Secretary for Benefits enter into a matching agreement with the Social Security Administration to identify incarcerated veterans and make benefit adjustments. Until such an agreement is made, VAROs should obtain this data from Federal Bureau of Prisons, State, and local prison officials. Also, overpayments should be established and collected for current and past incarcerations that were not adjusted. Compensation & Pension Service should monitor the program and monthly progress reports should be provided to ensure that

appropriate progress is being made to adjust benefits and establish overpayments.

VBA's Deputy Under Secretary for Management concurred with the findings and recommendations and provided acceptable implementation plans. (*Evaluation of Benefit Payments to Incarcerated Veterans*, 9R3-B01-031, 2/5/99)

**Issue: Data integrity for veterans claims processing timeliness.**

**Conclusion: VBA needs to improve data input to ensure accurate measurement of claims processing.**

**Impact: Enhanced customer service.**

We conducted an audit to assess the accuracy of three VBA performance measures used for Government Performance and Results Act reports: average days to complete original disability compensation claims, average days to complete original disability pension claims, and average days to complete reopened compensation claims.

Data used in the measurement of claims processing timeliness were not accurate. Comparisons of data from automated systems with source documents for three random samples of claims completed in FY 1997 disclosed that 30 percent of the records in each of the three samples were inaccurate or misleading. As a result, reported average processing times were inaccurate and implied better timeliness than actually occurred. We made recommendations to improve data input to the automated systems and to clarify policies.

VBA took immediate action to develop an end product transaction database for field facilities to enhance review and oversight of data input to automated systems. VBA also established a Data Management Office to enhance the quality

## Office of Audit

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of all data collection, reporting, and analysis activities. Additionally, VBA began field visits to enhance the quality of data collected and to clarify VBA policies. (*Audit of Accuracy of Data Used to Measure Claims Processing Timeliness, 9R5-B01-005, 10/15/98*)

**Issue: Education Service's quality review system.**

**Conclusion: VBA oversees an effective quality review system.**

**Impact: Assuring program integrity.**

The purpose of the review was to determine whether VBA's Education Service quality review system identifies program deficiencies and their causes, recommends corrective action, and follows up to ensure corrective action was taken. This is one of a series of reviews assessing VBA quality review systems. During FY 1998, Education Service administered about \$1 billion in education benefit payments to 435,000 veterans, servicepersons, and dependents or survivors of veterans and processed about 1.12 million benefit award actions.

Based on a statistical sample of benefit award cases that had been quality reviewed by Education Service during FY 1997, we concluded that Education Service had an effective quality review system. Deficiencies and their causes are identified and reported to local and central office management and followed up on to ensure they are corrected. The quality review system is effective because it evaluates the accuracy of benefit awards and validates important performance measurement indicators, including reported performance on case processing timeliness and productivity.

We also found that Education Service had enhanced its oversight of compliance surveys, and provided guidance and training to local staff to help them detect and prevent benefit fraud. Civil settlements are being obtained from some

student veterans who received VA benefits but did not attend regularly scheduled classes at a community college. Because VBA was restructuring compliance survey activities, Education Service's quality review results regarding compliance surveys were not included in the scope of this review. However, we believe that Education Service has effectively enhanced its compliance survey protocol in an effort to detect and prevent similar benefit fraud schemes. The Deputy Under Secretary for Management concurred with the audit results. We consider the issues resolved and may reevaluate the compliance survey area after the restructuring has taken effect. (*Review of Education Service's Quality Review System, 9R1-B18-012, 11/25/98*)

**"Your validation of our methodology is important to us."**

**VBA's Deputy Under Secretary for Management**

**Issue: Vocational Rehabilitation and Counseling (VR&C) Service's quality review system.**

**Conclusion: Implementation of the system will improve program accountability and integrity.**

**Impact: Assuring program integrity.**

The purpose of our review was to determine whether VR&C Service had an effective quality review system. During FY 1998, the Service reported expenditures of about \$403 million to rehabilitate an estimated 53,000 veterans. We found that in 1995 the Service had discontinued quality reviews. Because VR&C Service did not have a quality review system, our review focused on determining whether sufficient management controls were in place to ensure that program services were delivered in a timely and cost-effective manner, and program

payments were appropriate and accurate. Our review of a statistical sample of current vocational rehabilitation cases from one VARO identified both local and systemic management control weaknesses in the following areas: (i) accuracy and integrity of cost accounting records and program performance data, (ii) appropriateness of procurement decisions, and (iii) program management decisions.

We concluded that the \$400 million vocational rehabilitation program was at high risk because few management controls were in place to ensure program integrity and accountability. Lack of control and oversight heightened the risk of fraud; we referred a number of matters for criminal investigation. The Director, VR&C Service agreed with our findings and conclusions, and also agreed they related to systemic issues. During our review, the Director began a number of initiatives to address these matters, including the establishment of a quality review system. We made several recommendations to improve management controls over the vocational rehabilitation program and to strengthen VR&C program accountability, integrity, and cost-effectiveness. The Under Secretary for Benefits concurred with the findings and provided acceptable implementation plans for the recommendations. (*Review of Vocational Rehabilitation and Counseling Service's Quality Review System, 9R1-B18-044, 2/24/99*)

**“We would like to acknowledge the complex task you and your staff undertook to help VR&C program improve the delivery of services to veterans.”**

**VBA's Deputy Under Secretary for Management**

## Loan Guaranty

**Issue: Defaulted VA home loans.**

**Conclusion: Prepurchase counseling would benefit active duty service members who are homebuyers.**

**Impact: Reduce VA home loan defaults.**

We reviewed the effect of the implementation of VA's Housing Credit Assistance program policies on loan defaults. Also, we assessed the reliability, accuracy, and completeness of information in two of VA's loan guaranty data systems, used for: (i) loan originations, and (ii) operational control, and the servicing and reporting of defaults, claims, and liquidation of loans.

Loans made to active duty service members defaulted more often than loans made to veterans and also tended to default earlier in the loan period. Service members may be more prone to default on loans due to several factors, including: inexperience at handling debt, difficulty in coping with mortgages when transferred to other duty stations, or after being discharged. Most of the data fields (84 percent) we reviewed contained accurate data. As VA progresses toward allowing lenders to enter loan data directly into its computer systems, the process will become more efficient.

We recommended prepurchase counseling for service members who were in their first enlistment or were first-time homebuyers. The Deputy Under Secretary for Management agreed and proposed establishing a prepurchase counseling requirement for all first-time homebuyers. This requirement may require a regulatory change. In addition, we recommended that coding options for “reasons for liquidation” be broadened to allow staff to more appropriately categorize the reason. The Deputy Under Secretary agreed to revisit codes for reasons for default and liquidation, and to consider OIG's remarks in developing the new

Loan Servicing and Claims System. (*Attributes of Defaulted VA Home Loans, 9R5-B10-047, 3/25/99*)

## Office of Financial Management

### VA's Financial Statements

**Issue: VA's Consolidated Financial Statements (CFS) for FYs 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. We qualified our audit opinion concerning Housing Credit Assistance (HCA) program related balances for intragovernmental accounts receivable, loans receivable and related foreclosed property, liabilities for loan guarantees, and resources payable to the Treasury contained in VA's CFS. We were unable to satisfy ourselves as to whether the recorded balances were reasonable.

Our report on internal control discusses two material weaknesses concerning VA-wide information system security controls and HCA program accounting, and a reportable condition regarding medical facility accounts receivable. 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 report for FY 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 requirements concerning HCA program financial management information systems, information system security, and cost accounting standards, and provisions of the Credit Reform Act as it relates to guarantees on HCA loans sold. 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 identified noncompliance with two laws that, while not material to the financial statements, warrant disclosure. One concerns requirements for charging interest and administrative costs on compensation and pension accounts receivable. The other concerns the requirement that agents of the Government receiving money for the Government shall deposit the funds with the Treasury as soon as practical.

The Assistant Secretary for Financial Management stated appropriate offices have reviewed the report and concur with the reported findings and recommendations. (*Audit of VA's Consolidated Financial Statements for FY 1998 9AF-G10-061, 3/10/99*)

**Issue: Financial management.**

**Conclusion: Five 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 five management letters addressing financial reporting and control issues. The management letters provided Department managers additional observations and advice that, while not material

in relation to the CFS, will enable the Department to improve day-to-day accounting operations and controls. The management letters contained observations concerning: (i) medical facility accounts receivable; (ii) payroll transactions; (iii) accuracy of property, plant, and equipment reporting and controls; and (iv) ADP security.

No conditions were noted that had a material effect on the FY 1998 CFS, but correction of the conditions is considered necessary for effective operations. Where needed, appropriate adjustments were made to financial statements.

*(i. Management Letter: Accuracy of FY 1998 Medical Facility Accounts Receivable Financial Information, 9AF-G10-067, 3/31/99;*

*ii. Management Letter: Accuracy of VA's Payroll Data for FY 1998, 9AF-G10-065, 3/29/99;*

*iii. Management Letter: Accuracy of FY 1998 Property, Plant, and Equipment Financial Information, 9AF-G10-066, 3/26/99;*

*iv. Management Letter: ADP Security at Carl T. Hayden Medical Center, 9AF-G10-068, 3/17/99; and*

*v. Management Letter: ADP Security at Southwest Healthcare Network, 9AF-G10-018, 12/9/98)*

## Postaward Contract Reviews

**Issue: Contractor overcharges for pharmaceuticals.**

**Conclusion: Postaward audits and surveys disclosed overcharges.**

**Impact: Recovery of \$8.6 million.**

- A pharmaceutical manufacturer remitted \$8 million to VA for contract overcharges resulting from not disclosing accurate, complete, and current pricing and discount information to the contracting officer during negotiations on four contracts. The contractor's failure to disclose their most favored customer discounts denied the Government the opportunity to negotiate more favorable discounts.

- We completed 10 Public Law 102-585 compliance reviews. For 3 of the 10 companies we discovered errors in the calculation of Federal Ceiling Prices that resulted in contract overcharges. The companies agreed to pay \$470,740 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 company could be assured that their systems were producing accurate Federal Ceiling Prices.

**Issue: Contractor overcharges for medical equipment and supplies.**

**Conclusion: Postaward audits disclosed contract overcharges.**

**Impact: Recovery of \$86 thousand.**

- A medical equipment and supply company remitted \$71,536 to VA for contract overcharges resulting from not disclosing accurate, complete, and current pricing and discount information to the contracting officer during negotiations.

- A medical supply company remitted \$14,337 to VA for contract overcharges



resulting from not disclosing accurate, complete, and current pricing and discount information to the contracting officer during negotiations

### **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 funds of \$23.9 million.**

- A preaward review of a x-ray film and equipment company's offer resulted in potential contract savings of \$20,640,256.
- A preaward review of a pharmaceutical company's offer resulted in potential savings of \$2,409,502.
- A preaward review of a wheelchair manufacturer's offer resulted in potential savings of \$680,400.
- Two preaward reviews of medical equipment and supply companies' offers resulted in potential savings of \$170,000.

## **Multiple Office Action**

**Issue: Government purchase card program.**

**Conclusion: Management controls were not effectively implemented and cost-efficiencies were not achieved.**

**Impact: Better use of \$22 million.**

The purpose of the audit was to evaluate the effectiveness and efficiency of the purchase card program. VA-wide use of the program grew from 170 cards issued with 2,400 transactions valued at \$567,000 in FY 1994, to over 34,100 cards issued with 1.1 million transactions valued at \$592 million, as of April 1998. Purchase card expenditures for FY 1998 were expected to exceed \$1 billion.

We found the program is sound in principle and has clearly created opportunities for cost-savings and other benefits. VA has provided facility managers with procedures to monitor and control purchase card use. However, VA facilities did not effectively implement these management controls to ensure the integrity of the program.

Reconciliations of billing statements were either not performed, or were not performed timely; and, approving officials were not certifying the reconciliations timely. In addition, VA did not have a system in place to monitor facility reconciliations of billing statements. In October 1997, VA had about 38,000 unreconciled transactions valued at \$21.9 million, including over 33,200 valued at \$19.2 million that were not reconciled timely. About 11,600 of these transactions, valued at \$6.7 million, were over 60 days old. As a result, we believe that reconciliation of card transactions should be considered for reporting as an internal weakness because basic controls against erroneous and unauthorized transactions were not implemented.

We also found that VA did not achieve the cost-efficiencies expected from reengineering the acquisition and payment processes made possible by implementation of the program. Achieving the efficiencies could result in additional staff reductions totaling over \$22 million.

We recommended that the Assistant Secretary for Financial Management strengthen controls by (i) considering the reconciliation process as a material weakness, (ii) establishing appropriate mechanisms to monitor unreconciled transactions on a VA-wide basis, (iii) establishing mechanisms to ensure that deficiencies identified are effectively communicated to program officials, and (iv) monitoring corrective actions to ensure desired results are achieved. We also recommended the Under Secretary for Health realign staff commensurate with savings anticipated from implementing the program. (*Audit of VA's Purchase Card Program, 9R3-E99-037, 2/12/99*)

**“We appreciate the thoroughness and cooperation of your auditors, who have assisted us in prioritizing areas for improvement relating to the purchase card program.”**

**Under Secretary for Health**

**Issue: Management of medical supply inventories.**

**Conclusion: VAMCs could reduce excess inventories by more effectively using automation and other modern inventory techniques.**

**Impact: Better use of \$75.6 million.**

We evaluated how effectively VAMCs managed their inventories of medical supplies. In FY 1998, VAMC medical supply purchases totaled \$467.8 million. At any given time, the value of medical supply inventories at VAMCs was about \$103.8 million.

VHA and A&MM have encouraged VAMCs to modernize and improve inventory management. However, VAMCs still maintain large medical supply inventories that far exceed requirements for current operating needs.

Our audit at 5 VAMCs with combined medical supply inventories valued at \$7 million found that about \$4.3 million was excess. Based on the audit results, we estimated that at any given time the value of VHA-wide excess inventory was \$64.1 million, which was 62 percent of the \$103.8 million total inventory. Of the \$64.1 million in excess inventory, at least \$10.8 million was inventory for which there was no demand.

The excess inventories occurred because VAMC 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 had more effectively used automated inventory controls.

We estimated that stronger inventory management could reduce VHA medical supply inventories by \$75.6 million, which is the midpoint between two inventory reduction goals, a minimum goal of 30 days supply

(\$64.1 million) and a more aggressive goal of 7 days supply (\$87.2 million).

We recommended that VHA: (i) issue guidance requiring VAMCs to establish goals for inventory reductions and to use automation and other modern techniques for managing their inventories, (ii) establish procedures to monitor progress in reducing inventories, and (iii) provide VAMC staff training aimed at improving inventory management. We also recommended that A&MM provide VHA technical support and assistance in preparing the recommended guidance on inventory management and in providing the recommended training. The Under Secretary for Health and the Assistant Secretary for Financial Management concurred with the recommendation, and provided acceptable implementation plans. (*Audit of VAMC Management of Medical Supply Inventories, 9R8-E04-052, 3/9/99*)

## 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 Office of Management and Budget designated pilot agency for performance measurement. As such, VA began establishing performance measures for its programs and operations in FY 1992.

In FY 1995, the Office of Audit conducted three reviews to assess VA progress in implementing the strategic planning and performance measurement requirements of GPRA.

Overall, the results of these reviews showed that, while VA departments had made progress implementing strategic plans, the agency was a long way from achieving the ultimate goal of using performance measurement as a tool for improving the efficiency, effectiveness, and economy of VA operations. For example, Departmental strategic plans either did not include program or performance measures or incorporated measures which were not sufficiently specific and quantifiable to measure whether goals and objectives were achieved.

The Office of Audit recommended establishing:

- More specific and quantifiable performance measurements to assess whether goals and objectives were achieved.
- Management responsibility and accountability for the development and implementation of the strategic plan.

In FY 1998, at the request of the Assistant Secretary of Policy and Planning, we initiated a

multi-stage audit to examine the integrity of the data used for GPRA reports. There will be a series of audits to evaluate VA's most critical GPRA performance measures for validity, reliability, and integrity of the data.

The first audits assessed the accuracy of the following three VBA Performance Measures:

- Average days to complete original disability compensation claims.
- Average days to complete original disability pension claims.
- Average days to complete reopened compensation claims.

We found that VBA needs to improve the accuracy of data input to ensure accurate measurement of claims processing timeliness. For example, more than 30 percent of the records in each of the three samples contained inaccurate or misleading data, which resulted in inaccurate measurement of average processing times. Data from the automated systems used in developing GPRA reports indicated average processing times for all three samples were shorter than the actual processing times.

#### 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 five VHA performance measures and one NCA performance measure. These measures are:

#### VHA Performance Measures:

- Number of unique patients.
- Prevention index.
- Bed days of care per 1,000 unique patients.
- Chronic disease index.
- Addiction severity index.

#### NCA Performance Measure:

- Percent of the veteran population served by the existence of a burial option within a reasonable distance of the place of residence.

We will issue reports on each performance measure as audits are completed. Those reports done to date are:

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

*Review of Implementation of National Cemetery System'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.*



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# OFFICE OF HEALTHCARE INSPECTIONS

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## 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 13 FTE allocated, all of whom work in OIG headquarters. They are deployed 100 percent in healthcare inspections and evaluation issues.

We plan to hire 18 additional employees in the second half of FY 1999; these employees will be deployed in three regional offices.

## Overall Performance

### Output

- We published 20 final reports during the reporting period.

### Outcome

- We made 82 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 4.4 on a 5.0 scale for the year.

OHI inspectors have continued to emphasize the need for VHA to strengthen its quality management infrastructure by developing and pursuing a variety of quality management (QM) related projects and reports. These projects included reviews of VHA's deployment of QM structure and resources, an analysis of VHA employees' implementation of the patient safety

improvement policy, and an evaluation of VHA's oversight of state veterans homes. OHI also strengthened its VHA quality of care oversight by developing a more deliberative and stringent process for selecting and assigning Hotline allegations, which will ultimately improve our ability to complete and report on these reviews more promptly. We established closer working relationships with VISN clinical managers in our ongoing effort to strengthen the quality program assistance (QPA) review process. This relationship helped us to use the QPA effectively in the context of inspecting several sensitive Hotline allegations at VAMCs.

## Veterans Health Administration

### Nationwide Healthcare Program Reviews

**Issue: VHA's responsibility to oversee and evaluate care provided to veterans in State Veterans Homes (SVH).**

**Conclusion: SVH inspections frequently do not adhere to VHA guidelines because employees do not understand their responsibilities.**

**Impact: Enhanced ability to ensure patient safety and health care in SVH.**

The VA reimburses SVHs a per diem allowance for each eligible veteran who occupies a SVH bed. VA policy requires that parent VAMC employees inspect SVHs annually in order to ensure optimal quality of care and to verify the names of veterans who are receiving care. If VAMC inspectors identify problems with care, they should recommend improvements and

## Office of Healthcare Inspections

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follow up to ensure that SVH managers have effected the improvements.

We found several instances in which VAMC employees had identified operational discrepancies, but had either not made corrective recommendations, or had failed to follow-up to ensure that SVH managers had corrected the problems.

In one case, we found that veterans who were occupying an older wood frame residence were smoking without anyone paying attention to the safety issues. The building had a history of smoking-related fires, and VAMC inspectors were aware of the problem. However, SVH managers asserted that smoking was a human rights issue, and that the State refused to support a nonsmoking initiative. Inspectors stopped reporting on the issue, and no one followed up with the SVH or State officials in order to discontinue the hazardous smoking practices.

The Under Secretary for Health agreed with our conclusions and recommendations and provided appropriate implementation plans. (*Evaluation of VHA's State Veterans Home Inspection Process, 9HI-A06-014, 1/25/99*)

**Issue: VHA staffing, structure, and resources allotted to the QM process.**

**Conclusion: QM program is an effective program, but improvements are needed.**

**Impact: Managers can be more knowledgeable and effect patient care improvements with a fully integrated and consistent operating program.**

VHA has operated a health care QM program for more than 30 years. The program is in a continuous state of change, in keeping with developments in health care evaluation and electronic data processing technology. This

report analyzes VHA's QM programs at the headquarters, VISN, and VAMC levels. We also compared VHA's QM staffing and organization structure with two large private sector health care organizations. This program evaluation followed up on our February 1998 review of VHA's QM Programs. Both program evaluations were done at the request of the Senate Committee on Veterans' Affairs.

We were concerned that QM manpower, technological capability, resource availability, and organization structure are not adequate to meet QM's ever changing needs and clinician demands. We continue to be concerned that the QM program is not adequately staffed to perform its mission of evaluating and improving patient care. Most particularly this concern applies to QM's staffing and leadership within the VHA Office of Performance and Quality.

VISN-level staffing appears to be improving, but recently authorized QM officer positions are not yet fully staffed. These positions are vital to ensuring consistent leadership and oversight of local VAMC QM program activities.

Local medical center QM programs do not have consistent staffing, operating philosophies, or practices. There is significant staffing disparity among VAMCs; this needs to be stabilized. Some medical centers provide thorough QM evaluations and oversight of a wide variety of health care practices, and engage in total quality improvement, while other programs provide narrowly defined and limited oversight evaluations of only those patient care practices that are defined and required by VHA policies.

Similarly, medical center QM offices have different titles among the 172 VAMCs. These variations in office and employee titles, available resources, and broadly differing work initiatives can potentially lead to QM employees' loss of identification or association

with the purpose for which their organizations were established.

We reiterated from our February 1998 report that VHA needs to establish national QM guidelines that would incorporate such important practices as patient safety, sentinel event reporting, and lessons learned communication. We found that many VISNs already have a similar set of guidelines, and these could be disseminated throughout VHA as an example of “best practices.” The Under Secretary for Health concurred, or concurred in principle, with our recommendations and provided responsive implementation plans. (*Evaluation of Quality Management Staffing and Resources in VHA, 9HI-A28-042, 2/18/99*)

**Issue: Need for prompt reporting and distribution of information pertaining to serious patient incidents.**

**Conclusion: VHA employees are knowledgeable of their responsibilities for reporting incidents, even though they frequently do not do so. Managers are generally effective in communicating information to prevent future patient harm.**

**Impact: The ability to ultimately prevent patients from incurring harm as a result of similar serious incidents.**

The Chairman, House Committee on Veterans’ Affairs, Subcommittee on Health, asked the OHI to determine how effectively VHA employees implemented selected aspects of VHA’s January 1998 Patient Safety Improvement policy. The Chair made this request in view of two similar serious incidents that resulted in serious consequences for patients who were confined in soft restraints. He was particularly interested in the patient safety alert system, and how effectively potentially preventive information

was disseminated throughout the VHA health care system.

OHI inspectors reviewed the Boards of Investigations and supporting testimony and documents in the two sentinel events and reviewed investigative documents in a subsequent case that involved similar circumstances. We also interviewed more than 210 VHA employees in 10 randomly selected VAMCs. These employees ranged in responsibility from executive managers to individuals at the “sharp end” who directly care for patients, and who most critically have to be aware of information on how to safeguard patients from harm.

We found that VHA employees are aware of their responsibilities to report serious events. However, employee memories of a former environment, in which punitive actions were closely associated with incurring or reporting an error, continue to impede full reporting.

VAMC managers and clinicians who conduct Boards of Investigations are frequently not properly trained to conduct sensitive and complex investigations and tend to miss or disregard important information or leads that could provide better answers as to why an incident occurred. Similarly, VAMC employees are often reluctant to investigate their peers, particularly when the event in question is particularly sensitive or resulted in serious patient consequences.

We concluded that VHA is in the process of developing an effective method for communicating potentially preventive information pertaining to serious incidents, and that for the most part, this procedure is followed effectively at the VISN and VAMC levels.

We found, however, that mid-level managers, in 4 of the 10 VAMCs that we visited elected not to communicate this information to lower level



employees. They refrained on the basis that they did not use the same equipment as that used where the serious incidents occurred. These decisions were flawed. This is demonstrated by the fact that managers in the second facility where a serious soft-restraint incident occurred had decided not to give this information to lower level employees because the soft restraints they used were not the same brand or model as that implicated in the first incident.

The Under Secretary for Health concurred, or concurred in principle, with our recommendations and provided responsive implementation plans. (*Oversight Evaluation of VHA's Implementation of Its Patient Safety Improvement Policy in Two Sentinel Events, 9HI-A28-051, 3/2/99*)

### QPA Reviews

**Issue: VAMCs' ability to provide optimal access to high quality, low cost, and timely health care.**

**Conclusion: Managers are working collaboratively to reorganize the health care process, but the scope and pace of changes often negatively affects employee morale.**

**Impact: Managers are developing initiatives to provide good, accessible care at an affordable cost.**

During this reporting period, OHI completed three QPA reviews. Two of these QPA reviews were done in the context of inspecting and resolving a variety of allegations about clinical and administrative issues. This concurrent review process not only allowed OHI inspectors to review the events surrounding the allegations critically; it also provided a context in which to view the perceptions that led to the allegations.

In all three QPA reviews, OHI inspectors concluded that medical center executive

managers were working collaboratively, with varying degrees of success, to initiate programmatic changes that were designed to improve veterans' access to high quality health care. Managers were also developing and implementing strategies that reduced operating costs and allowed them to reprogram funds so that more money would be available for direct patient care. In all three cases, executive and mid-level managers held positive attitudes about the changes that were underway. Similarly, with one exception, clinicians were generally very supportive of the organizational and operational changes that had occurred and believed that these changes had improved the quality and accessibility of patient care.

VAMC Togus was experiencing what clinicians and patients perceived to be draconian reductions in operating resources which they believed threatened the medical center's ability to ensure access to quality care and possibly threatened the ability of clinicians to provide sound health care.

Patients had generally positive impressions about recent improvements in care, accessibility, and employee attitudes that occurred in association with the changes.

Notwithstanding the generally positive impressions that we reported in our previous semiannual report, employees who responded anonymously to our QPA questionnaires raised concerns that the rapid pace and broad scope of the many organizational and operational changes that have occurred have increased personal tensions and reduced employee morale. Employees appear to attribute their concerns to uncertainties about job security and perceived increased workloads or insufficient staffing situations in their particular work areas. Executive managers at all three VAMCs have established intensive communication initiatives to keep employees and other stakeholders fully informed about ongoing and contemplated

organizational and operational changes. However, employees continue to hold negative impressions about the change process.

OHI continues to be concerned that the issues of degraded employee morale, and increased tensions in the workplace, have the potential to lead to diminished quality of care, lowered patient satisfaction, or the occurrence of adverse patient incidents. Thus, we believe that VHA managers need to seriously consider ways to alleviate these employee problems. (*Reports: QPA Reviews, VAMCs San Juan, PR; Togus, ME; and Northport, NY; 9HI-F03-011, 11/9/98; 9HI-A28-039, 2/17/99; and 9HI-A28-062, 3/17/99*)

### Healthcare Hotline Inspections

**Issue: Verbal patient abuse, failure to monitor anticoagulant patients, unethical employee conduct, and mismanagement of a fee-basis program at VAMC San Juan, PR.**

**Conclusion: Employees were respectfully and properly caring for patients, and had appropriately managed fee-basis operations.**

**Impact: Procedures serve to safeguard patient well being and improve care.**

We inspected allegations that VAMC San Juan clinicians and clinical managers frequently verbally abused patients; that nursing employees did not adequately monitor clotting levels of patients who were receiving anticoagulant therapy; that some employees improperly divulged sensitive medical information about patients to unauthorized sources; and that employees did not adequately monitor the fee-basis program, such that many patients received more fee-basis treatment than they required.

Our inspection failed to confirm the allegations. We found that there may have been a problem

with inadequately monitoring all anticoagulant patients at one time, but local managers had identified this problem in its earliest stages and developed strong anticoagulant therapy criteria and monitoring procedures. These measures ensure that all patients who are receiving anticoagulant drugs are consistently and intensively monitored in order to avoid any problems with excessive clotting times or the development of uncontrolled bleeding.

*(Inspection of Alleged Mismanagement of Fee-Basis Program and Patient Mistreatment, VAMC San Juan, PR, 9HI-A28-006, 10/23/98)*

**Issue: Lack of fully informed consent associated with inadequate information about potential operative complications at VAMC Tampa, FL.**

**Conclusion: Clinicians informed the patient about potential complications of surgery and the patient signed the operation consent form.**

**Impact: Better understanding of patients' emotional reaction to potentially devastating surgical complications.**

We inspected allegations that VAMC Tampa urologists failed to inform a patient properly and completely that a proposed prostate operation could result in permanent impotence and other unpleasant complications. The complainant asserted that he would never have consented to having the operation had he known about the potential for these problems to occur. However, the patient's medical records contained adequate documentation to show that the urologist had extensively discussed the procedure with the complainant and that the complainant appeared to understand the potential risks. The complainant evidently did not recall this conversation.

Even though we did not substantiate the allegation, we recognize the complainant's

concerns, and recommended that the Director ensure that clinicians offer him a second opinion as to how he can best deal with his surgically incurred complication. The Medical Center Director concurred with our recommendation and took immediate action to provide the complainant with a second opinion. (*Inspection of Alleged Inadequate Informed Consent for Surgery, James A. Haley Veterans' Hospital, Tampa, FL, 9HI-A28-017, 12/8/98*)

**Issue: Five unrelated adverse patient care events that managers at VAMC Miami had already investigated thoroughly.**

**Conclusion: Managers had not consistently followed up on corrective actions to ensure implementation.**

**Impact: Unimplemented corrective actions can lead to repetition of serious adverse patient events.**

We inspected allegations that VAMC Miami managers had ignored or covered up five serious adverse patient events and did not take any corrective actions to improve patient safety as a result of these incidents. We reviewed the medical center's Boards of Investigations, root-cause analyses, and other documents associated with these five incidents. We also interviewed the principals who were involved with each incident and quality managers who are responsible for coordinating and tracking the investigative process.

We concluded that managers had adequately dealt with all of the incidents, from an investigative standpoint, and that there is no indication that anyone attempted to obscure the facts in any of the cases. Medical center managers had initiated corrective actions to prevent, or reduce the potential for, any of these incidents to reoccur.

However, managers failed to follow up adequately on recommended corrective actions intended to strengthen patient search procedures in the case of a patient who wandered from his treatment area and was subsequently found in a construction area. Approximately 1 year after the first inadequate patient search incident occurred, another patient wandered from his ward and was later found dead, from a fall in a stairway, adjacent to another construction site. The County Medical Examiner concluded that the patient had suffered a heart attack and was dead before he fell down a flight of steps, but medical center managers acknowledged that it took too long for searchers to locate the patient.

We found that managers had not established formal tracking procedures to ensure that recommended actions take place, and the medical center had not strengthened the patient search policy and procedure as had been recommended in an earlier investigation. We recommended that the Director establish a reliable procedure for tracking issues that are based on corrective recommendations to ensure their prompt completion. The Medical Center Director concurred with our recommendation and took immediate action to establish an implementation tracking system through the QM office. (*Inspection of Five Adverse Patient Care Events at VAMC Miami, FL, 9HI-A28-019, 12/16/98*)

**Issue: Alleged disrespectful and inattentive treatment in retaliation for a patient's inability to follow instructions at VAMC Tampa, FL.**

**Conclusion: Allegations could not be confirmed. The complainant refused to elaborate on the specifics of the case.**

**Impact: Increased sensitivity to debilitated patients' problems leads to better patient care.**

We inspected allegations that Nursing Home Care Unit (NHCU) nursing employees at VAMC Tampa punished a patient for his inability to follow nursing instructions by: (i) making him lie in his own waste for 2 hours, causing him to develop bed sores, and (ii) causing him to fall out of his wheelchair by not adequately securing him in the chair. Clinical employees also allegedly treated the patient disrespectfully, and in an insensitive and condescending manner, not recognizing or appreciating the loss of dignity and self-respect that he incurred as a result of a recent cerebrovascular accident (stroke).

We found that NHCU clinical managers had completed an incident report as required, but did not fully investigate the alleged incidents because the complainant refused to provide necessary basic information in order to allow investigators to focus on a time, place, or alleged perpetrator. Even so, the NHCU clinical manager provided all employees with sensitivity training, and increased the number of licensed nursing employees in the unit.

The patient's medical records do not show any indication that he ever had a bed sore, but he did have a rash on his inner thighs, associated with urinary incontinence, that nursing employees properly treated with antibacterial ointment. We also found that the patient fell from his wheelchair when he attempted to self-transfer from his chair to the toilet without seeking assistance from nursing employees. Since we did not find any untoward practices, we did not make any recommendations. (*Inspection of Alleged Nursing Non-Attendance, Lack of Compassion, and Verbal Abuse, James A. Haley Veterans Hospital, Tampa, FL, 9HI-A28-023, 1/7/99*)

**Issue: A patient eloped from an unsecured ward at VAMC Tuskegee and disappeared.**

**Conclusion: Nursing employees did not properly monitor an incapacitated patient who was known to wander.**

**Impact: Strengthened patient surveillance and evaluation practices will improve patient safety.**

The House Committee on Veterans' Affairs asked OHI to inspect the circumstances surrounding a patient's disappearance from the VAMC Tuskegee campus. We found that clinical employees' had become inured to the patient's tendency to wander away from the ward without notifying employees that he was leaving. He had always returned in the past.

Nursing employees also asserted that the ward was so understaffed that no one had the time to escort patients to extra-ward activities. Thus they allowed the patient to go to a recreation activity unaccompanied. When employees realized that the patient was not going to return to the ward, they properly initiated a missing patient alert, and medical center managers initiated a prompt and comprehensive search for the patient that included searchers from the local community as well as medical center employees. However, searchers failed to locate the patient.

We made six recommendations to address the issues that we identified during our inspection. The Acting Medical Center Director concurred with our recommendations and provided responsive implementation plans. (*Inspection of Search Procedures for an Allegedly Missing Patient, VA's Central Alabama Health Care System, Tuskegee, AL, 9HI-A28-025, 1/11/99*)

**Issue: Alleged inadequate patient care at VAMC Tampa, FL.**

**Conclusion: We did not substantiate the allegations that clinicians improperly used an arterial catheter balloon or an aortic balloon pump; better security would have reduced the possibility that a patient could wander from the ward.**

**Impact: Strengthened patient surveillance and wandering prevention practices would improve patient safety.**

The VHA's Office of Medical Inspector asked OHI to inspect three allegations pertaining to inadequate patient care practices at VAMC Tampa. One complainant alleged that clinicians had improperly inserted an arterial catheter with a balloon to dilate an obstruction of a patient's iliac artery, causing the balloon to rupture, and a balloon fragment to become lodged in the artery, leading to the need to perform more extensive, invasive surgery. In another case, a complainant alleged that improper use of an intra-aortic balloon resulted in the patient having to have an above-the-knee amputation. The third complainant charged that careless employees allowed a patient to escape from a locked ward.

We found that medical center managers had thoroughly investigated each of the incidents at the times that they occurred, and had failed to substantiate any of the allegations. In the first case, clinicians attempted to dilate a patient's diseased iliac artery with a catheter balloon. The balloon ruptured during the procedure, and a fragment of the balloon became entangled in the stent that surgeons had installed to maintain arterial patency. This problem required surgeons to perform an axillo-bifemoral bypass graft. Local investigators concluded that the arterial balloon was faulty, and they reported the incident to the manufacturer. We concurred with local investigators' conclusions and the corrective action.

In the second case, surgeons inserted an intra-aortic balloon pump into a patient's aorta during an emergency triple coronary artery bypass graft operation. The balloon passed easily but failed to inflate as it should. When surgeons were removing the balloon, the patient's right distal leg pulse was lost. Surgeons attempted to perform a right femoral-popliteal artery bypass, but they could not salvage the patient's leg. Again, we agreed with local investigators' conclusions that the balloon pump was faulty, and we agreed with their action of reporting the problem to the manufacturer. We did not identify any practitioner fault in either of these two separate incidents.

In the third case, a patient eloped from a secured ward, after he had been treated by local psychiatrists for more than 1 month for a serious mental health disorder. A nurse asked him to wait in a day room while she prepared to escort him to the chapel. When she returned, he had disappeared, and she immediately called a missing patient alert. The door to the secured ward was unlocked at the time. Local searchers could not locate the patient, but he appeared, about 6 days later, at his family's home.

We recommended that the Director consider installing a patient alarm system on the acute psychiatry ward. The Director offered alternative measures to our recommendation, including strengthened surveillance of certain psychiatric patients, increased employee sensitivity and awareness of elopement potential, and allowing ward egress through only one door. We believe that these alternative measures will effectively reduce the potential for a similar incident. (*Inspection of Alleged Inadequate Medical Care, James A. Haley Veterans Hospital, Tampa, FL, 9HI-A28-028, 1/26/99*)

**Issue: Alleged inadequate psychiatric nursing staff for safe patient care at VAMC Marion, IN.**

**Conclusion: A patient assaulted an employee when the ward was inadequately staffed.**

**Impact: Adequate staffing will ensure the safety of employees and patients.**

We inspected allegations regarding VAMC Marion, IN that there was inadequate nursing staffing on psychiatric wards to ensure employee and patient safety. A psychiatric patient had allegedly assaulted and raped a registered nurse on an evening when there were only two nursing employees to care for a fully occupied acute psychiatry ward.

We confirmed that the incident occurred and that the ward was inadequately staffed at the time of the incident. We also concluded that there were certain treatment areas in the medical center that were chronically under staffed. These understaffing situations occurred predominantly in the psychiatry wards.

We made three recommendations to remediate the situation. The Medical Center Director concurred with our recommendations and provided responsive implementation plans. *(Inspection of Alleged Unsafe Psychiatric Staffing Levels, VAMC Marion, IN, 9HI-A28-029, 1/29/99)*

**Issue: Alleged inadequate care, over-medication, and discharge planning for long-term mentally ill patients at VAMC American Lake.**

**Conclusion: Clinicians properly cared for patients, and did not administer excessive doses of medicines. Employees need to understand the duties of patients' guardians.**

**Impact: Improved understanding of the guardian versus the fiduciary process will better safeguard patients' rights.**

The Washington State Aging and Adult Services Administration asked OHI to inspect several allegations that they had received regarding purported inappropriate patient treatment practices at the VAMC American Lake campus. The complainants charged that clinicians inappropriately attempted to discharge an elderly, difficult-to-manage patient to a private sector nursing home, without input from the family; and that clinicians routinely over-medicated patients in order to make them easier to manage.

We found that clinicians had concluded that they could no longer provide an elderly, chronic, long-term psychiatric patient with meaningful therapy, and planned to out-place him to a community psychiatric nursing home that has a highly structured treatment program to manage difficult patients. Clinicians discussed their discharge plans with the patient's fiduciary guardian, instead of the guardian of the person. This error occurred because the court had administered the guardian issue for more than 25 years and had made several changes, which many employees did not understand. The patient's brother is his guardian of person, and clinicians should have consulted him instead. When the brother and his family objected to the out-placement plans, clinicians cancelled them.

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We determined that clinicians have established several controls to prevent excessive administration of psychoactive drugs. At least two physicians have to concur that such drugs are needed. Ward nursing employees have substantial input into the final psychoactive medication decisions, since nursing employees actively seek to find alternative means of reducing disturbed patients' agitation and aggressiveness. In addition, nurses are provided with regular inservice training on how best to treat difficult acute and chronic mentally ill patients without medication.

We recommended that the Director ensure that involved clinicians clarify and understand the guardianship status of all of the more than 200 patients who may have this protection. The Medical Center Director concurred with our recommendation and implemented immediate corrective actions. (*Inspection of Multiple Allegations of Improper Medical and Psychiatric Care for Long-Term Patients, VA Puget Sound Health Care System, American Lake Division, 9HI-A28-034, 2/2/99*)

**Issue: Alleged improper treatment of patients on two acute care wards caused by alleged understaffing at VAMC New Orleans, LA.**

**Conclusion: Wards were not understaffed; however, communication patterns were ineffective and feeding methods need better coordination.**

**Impact: Better employee communication will lead to better patient care.**

We inspected allegations that VAMC clinicians provided substandard patient care to patients on two acute care wards because the wards were inadequately staffed to provide good care. We did not substantiate that the wards were understaffed. However, we found that clinicians needed to improve interpersonal

communications in order to exchange important clinical information about patients and to ensure continuity of care in selected cases. We also found that inadequate communications led to a lack of assurance that all patients were properly fed at every meal time, although we did not identify any instance in which any patients were not fed.

We made three recommendations to improve employees' interpersonal relationships and communications and to ensure that managers could be assured that all patients are fed. The Medical Center Director concurred with our recommendations and provided responsive implementation plans. (*Inspection of Multiple Clinical and Administrative Allegations, VAMC New Orleans, LA, 9HI-A28-038, 2/10/99*)

**Issue: VAMC Phoenix, AZ oversight of State Veterans Home (SVH) operations.**

**Conclusion: Clinicians did not properly oversee correction of SVH discrepancies.**

**Impact: Adequate SVH oversight can improve care.**

We inspected allegations that VAMC Phoenix clinicians failed to provide required oversight of Arizona SVH operations or to follow up on known treatment deficiencies at the State facility. The VAMC has a statutory responsibility to inspect the Arizona SVH annually to certify that the level of care meets existing VA treatment standards.

We substantiated the allegations that VAMC inspectors found examples of substandard treatment practices at the SVH but did not adequately oversee or monitor the correction of these problems, thereby ensuring an adequate level of care. We did not find any instance in which any patients were actually harmed as a result of these substandard practices.

We made two recommendations to strengthen the medical center's SVH inspection process. The Medical Center Director concurred with our recommendations and provided appropriate implementation plans. (*Inspection of Alleged Substandard Patient Care in the Arizona State Veterans Home, Phoenix, AZ, 9HI-A28-041, 2/12/99*)

**Issue: Multiple allegations of inadequate treatment for a patient who had serious pulmonary disease at VAMCs Fayetteville and Little Rock, AR.**

**Conclusion: Inadequate medical record documentation and inadequate communication with family members led to perceptions of poor care.**

**Impact: Improved documentation, and strengthened communications enhance understanding of the treatment process.**

We inspected the circumstances surrounding the allegedly substandard care and avoidable death of a lung cancer patient. Family members alleged that a series of unnecessary delays in diagnosing the patient's cancer, and transferring him from VAMC Fayetteville to VAMC Little Rock for definitive surgery, and the ultimate decision not to operate urgently on the lung cancer, led to complications that required the patient to suffer brain death, and be placed on a mechanical ventilator until his ultimate death. Family members also were distressed that clinicians did not include them in the decision as to whether or when to operate on the patient.

We substantiated 3 of the complainants' 11 allegations. We found: (i) When radiologists were concerned about the diagnostic value of some of the x-rays that they had obtained, they should have repeated the films and obtained images from different positions in order to maximize the diagnostic adequacy. (ii) Clinicians should have recognized the patient's

compromised nutritional status and developed more definitive plans to ensure that he was adequately nourished. (iii) Two medication errors occurred, but did not affect the patient's ultimate demise.

We concluded that the time required to definitively diagnose the patient's cancer was reasonable given the intervening weekends, and that it was not viewed as an urgent situation because of the patient's otherwise good condition. The patient was competent, and fully functional, and it was his decision as to whether or not to involve family members in the surgical decision; apparently he elected not to include the family in the decision. However, after he was unconscious and on mechanical ventilation, it appears that clinicians communicated regularly with the family and included them in important treatment decisions.

It appeared to OHI inspectors and to consulting specialists that both VAMCs' clinicians provided adequate and appropriate care for the patient, given his age, and the seriousness of his other physical conditions. However, clinicians failed to adequately record several of their interventions and their decision making processes in the patient's medical record, making it difficult to make a post-treatment judgment about the appropriateness and timeliness of all of their treatment decisions.

We made several recommendations to remediate the problems that we identified in the course of this inspection. The Medical Center Directors concurred, or concurred in principle, with all of our recommendations and provided responsive implementation plans to correct the problems. (*Inspection of Alleged Failure to Provide Surgery and Appropriate Medical Care, VAMCs Little Rock and Fayetteville, AR, 9HI-A28-48, 2/26/99*)



**Issue: Alleged cover-up of circumstances surrounding a patient's suicide at VAMC Dayton, OH.**

**Conclusion: Managers had properly informed the patient's next-of-kin about the circumstances surrounding the patient's death, but this information had not been communicated to the son.**

**Impact: Providing complete information to all family members helps them deal with grief.**

We inspected the circumstances surrounding a patient's suicide at VAMC Dayton. The patient's son was convinced that medical center officials had covered up important information about his father's death, because they had not discussed the issues with him, even though he had asked for the information in writing, and in conversations with someone in the Director's office.

We found that the patient had been treated for mental health problems for an extended period of time, and that he had consistently denied having any thought or plan for committing suicide or any other violent act. We concluded that medical center clinicians conducted a thorough psychological autopsy into the patient's suicide, and had properly discussed the issues in the case with the patient's next-of-kin of record.

However, we suggested that the Director ensure that the patient's treating clinicians and the Chief of Staff meet with the complainant and thoroughly explain all aspects of the patient's care to him and his mother. The Director initiated this recommended meeting while OHI inspectors were on station, and the complainant informed us that he and his mother were satisfied with the answers that clinicians provided for their questions. We did not make any formal recommendations.

*(Inspection of Alleged Cover Up of a Patient's Death, VAMC Dayton, OH, 9HI-A28-069, 3/18/99)*

**Issue: Failure to diagnose a patient's colon cancer at VAMC Boston, MA.**

**Conclusion: Clinicians failed to make a very difficult diagnosis of colon cancer, but his cancer was so far advanced when he presented for care that curative treatment was not possible.**

**Impact: Family assured that diagnosis and treatment actions were reviewed.**

We inspected allegations that VAMC Boston clinicians had failed to diagnose a patient's colon cancer, and that private sector physicians diagnosed the condition and promptly operated to remove the tumor, but the patient died.

We found that VAMC clinicians did miss the cancer diagnosis, but concluded that the patient's condition and the tortuosity of his colon were such that missing the diagnosis was understandable. Clinicians performed a colonoscopy on the patient, but his bowel was compromised because of a blood-oxygen deficit, and they could not safely advance the colonoscope beyond the compromised part of the colon. Thus, they did not identify a possible tumor formation.

We also concluded that the patient's cancer was so advanced when he presented for treatment, that no surgical intervention would have been curative. Senior medical center clinicians reviewed the patient's entire diagnostic and treatment course and identified areas that may have been done better, but even with these improvements, identifying the patient's cancer would have been unlikely.

We did not find any treatment errors that medical center clinicians had not already

identified, and we did not make any recommendations. (*Inspection of Quality of Care Allegations, VAMC Boston, MA, 9HI-A28-077, 3/29/99*)

**Issue: Failure to obtain fully informed consent for a kidney removal, failure to explain bilateral leg amputations, and inadequate treatment for bedsores at VAMC West Los Angeles, CA.**

**Conclusion: Clinicians provided the patient with appropriate care and with the patient's fully informed consent.**

**Impact: Managers ensure that clinicians obtain and document informed consent.**

We inspected allegations that clinicians at VAMC West Los Angeles performed a nephrectomy on a patient when he entered the medical center for leg surgery, that surgeons amputated both of the patient's legs without explaining a rationale to the complainant, and that clinicians provided inadequate treatment for the patient's bedsores.

We found that the patient had severe peripheral vascular disease, which had greatly compromised the circulation to both of his legs and had caused his left kidney to stop functioning. The patient's medical record shows that clinicians thoroughly explained the need for him to have his left kidney removed, and to have an aorto-bifemoral bypass graft to attempt to restore circulation to his legs. The record shows that the patient appeared to understand what his physicians told him. Furthermore, he signed and dated a consent to have the operations performed.

At the time of surgery, clinicians successfully removed the patient's kidney, and began to perform the arterial bypass operation. However,

before the second operation could get underway, the patient experienced life threatening cardiac complications and surgeons aborted the bypass procedure with the intent of performing it when the patient recovered sufficiently from the nephrectomy. Unfortunately the patient's lower legs worsened because of the greatly compromised vascularity, and the difficulty involved in turning the patient because of his large size and many medical problems. Therefore, surgeons had to amputate both legs below-the-knees.

Following the second operation, the patient had to be connected to a mechanical ventilator. Surgeons made every reasonable attempt to communicate with the complainant, in order to ensure that she was aware of the patient's condition, and could consent, when and if the patient needed further surgical interventions. The patient subsequently became ventilator-dependent, and clinicians transferred him to a private sector rehabilitation hospital, where he could receive adequate chronic ventilator care. The patient died at the private hospital about 1 month after being transferred from the VAMC.

We concluded that while the patient was conscious and responsive, it was appropriate for him to consent to his surgical procedures. Clinicians contacted the complainant prior to the bilateral leg amputations and obtained her consent, by telephone, to have the procedures done. The physician who obtained the consent and the nurse who witnessed the telephone conversation both recorded their versions of the conversation in the patient's medical record. However, they did not record the conversation on tape and have it transcribed for entry into the record as required by VHA policy.

We made three recommendations to improve and strengthen VAMC employees' procedures for obtaining informed consents from patients' families or guardians and to clearly document patients' decision-making capacities. The

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VAMC Director concurred with our recommendations and provided us with appropriate implementation plans. (*Inspection of Alleged Poor Quality of Care, VAMC West Los Angeles, CA, 9HI-A28-079, 3/30/99*)

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# OFFICE OF MANAGEMENT & ADMINISTRATION

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## 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 operational and administrative 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. This includes controlling and referring many cases to impartial VA components having jurisdiction. The Data Analysis section provides automated data processing technical support.

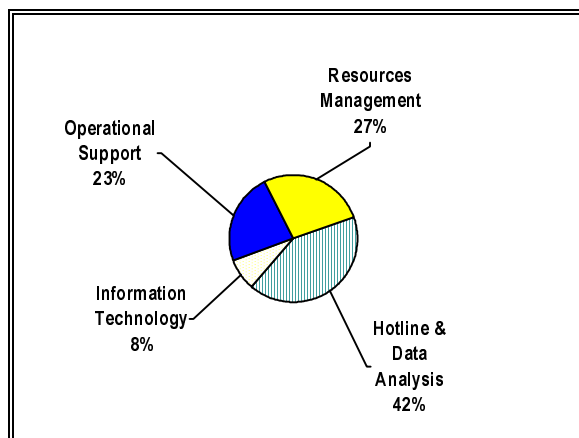
II. Operational Support Division - The Division does followup tracking of OIG report recommendations; Freedom of Information Act (FOIA) releases; strategic, operational, and performance planning; IG reporting and policy development; and Internet document management.

III. 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.

IV. Information Technology (IT) Division - The Division manages nationwide IT support, systems development and integration, and represents the OIG on numerous intra- and inter-agency IT organizations and does strategic planning for all OIG IT requirements. This Division was established during this reporting period; recruitment for the Division Director has just begun.

## Resources

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



## I. HOTLINE AND DATA ANALYSIS DIVISION

### Mission Statement

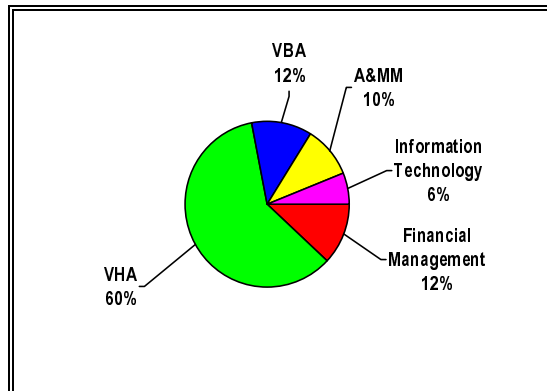
*Ensures that allegations of fraud, waste, abuse, and mismanagement are responded to in an efficient and effective manner. Provides automated data processing technical support to all elements of the OIG and other Federal Government agencies needing information from VA files.*

The Hotline Section operates a toll-free telephone service five days a week, Monday through Friday, from 5 AM to 10 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 7 employees in the Data Analysis Section; 1 statistician 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 7,470 contacts. Of this number, 323 cases were opened. The OIG reviewed 41 of these and the remaining 282 cases were referred to VA program offices for review.

#### Output

- During the reporting period, Hotline staff closed 296 cases of which 69 contained substantiated allegations (23 percent). The Hotline staff generated 159 letters responding to inquiries received from members of the Senate and House of Representatives.

#### Outcome

- VA managers took 28 administrative actions against employees and 35 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled \$50,828.

## A. HOTLINE SECTION

The Hotline Section's most significant leads are referred to other OIG elements, such as Healthcare Inspections or Administrative Investigations. Hotline staff retained oversight on a number of cases that were referred to

independent VHA and VBA program officials for resolution. Hotline staff members follow up on issues such as patient care, veterans' benefits, employee conduct, property, and use of public office for personal gain. The following are some examples of the cases that were closed during this reporting period.

## Veterans Health Administration

### Outside Employment

- A Hotline inquiry resulted in a substantiated allegation that a physician was holding clinics at outside hospitals while he was scheduled to work at the VAMC. The review found that the physician spent 215 hours (the equivalent of \$14,966) outside of the VA. The VAMC accepted the physician's voluntary resignation with the physician's agreement to reimburse VA for the salary he should not have been paid.
- In response to a Hotline inquiry, a VISN Director confirmed that a VAMC surgeon improperly obtained outside employment. The surgeon in question has agreed to pay back \$9,400 over a two-year period.

### Patient Abuse

As a result of a Hotline inquiry, a VHA review substantiated the allegations of employee misconduct by a VAMC employee, patient abuse, and poor quality of care. A Board of Investigation found that a nurse assaulted a psychiatric unit inpatient. The VAMC is pursuing removal action against the nurse. The VAMC is also taking other corrective actions to prevent recurrences.

### Patient Care and Service

- A VAMC review prompted by a Hotline inquiry disclosed that a service-connected veteran was inappropriately billed for prosthetic devices and care. The VAMC rescinded the charges and issued a letter of apology to the veteran.
- A VHA review in response to a Hotline inquiry disclosed that a patient was inappropriately billed for \$2,206. The veteran was hospitalized for treatment at a private mental health facility, as recommended by the VAMC. The VAMC authorized payment upon receipt of an itemized bill from the private facility.
- A VISN review substantiated the allegation that a VAMC emergency room misdiagnosis of a veteran's leg fracture resulted in surgery. Based on the Hotline inquiry, the VISN and the VAMC have implemented system safeguards to prevent recurrence of the emergency room misdiagnosis.

### Employee Misconduct

A VHA review prompted by a Hotline inquiry found that a Vet Center supervisor attempted to recruit a veteran he was counseling into a pyramid sales scheme involving natural herbal medications. The supervisor received a seven-day suspension and was required to take supervisory training and ethics classes.

### Quality of Care

As the result of a Hotline Inquiry, a VHA review found that a VAMC physician inaccurately completed a death certificate, resulting in the Medical Examiner holding the body and returning the death certificate to the facility three times for correction. VAMC officials counseled the physician and issued a corrected death

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certificate. On receipt of the corrected death certificate, the Medical Examiner released the veteran's body to the family for burial.

### **Gambling on Government Property**

A VISN review prompted by a Hotline inquiry found employee gambling at a VAMC. The review disclosed that 14 VAMC employees were gambling in a football lottery on VA property. All of the employees, including senior VAMC officials, were counseled regarding VA regulations about gambling activities on Government property.

### **High Profile Cohabitation in Station Quarters**

A VISN review in response to a Hotline inquiry substantiated the allegation that high profile cohabitation occurred in VAMC station quarters. The review found that two VAMC supervisors were or had been involved in questionable relationships with a subordinate and a lower graded employee. The VAMC Director is reevaluating the criteria used to determine rules of conduct for those employees living in station quarters.

### **Contracting Activities**

- A Hotline-prompted review at a VAMC failed to substantiate allegations that an ambulance service did not meet VA specifications. However, the review confirmed that air-conditioning units were not working in several of the ambulances. The VAMC terminated the ambulance service's contract.
- A Hotline inquiry that prompted a VHA review disclosed that a new accommodations program vendor was not providing handicapped accessible rooms to veterans referred by the medical center for overnight stays, as required by the contract. The VAMC required the new

vendor to make specific guest room modifications to accommodate wheelchair-bound patients.

- Based on a Hotline inquiry, an A&MM review found that a VAMC made a final payment to a vendor who did not complete a job. Additionally, the review found that the monetary value of the contract was improperly increased. A&MM is recommending that an on-site acquisition review be performed; the Office of Special Counsel is investigating a reprisal action related to this Hotline.

### **Government Equipment and Supplies**

- An OIG review found that a medical center director failed to report properly the loss of a hand-held computer valued at \$600 and did not use proper purchasing procedures when he replaced it and acquired other computer-related items. The director retained possession of the computer when he transferred to a new duty station. The investigation further substantiated that the director improperly received travel reimbursements by third party draft checks, and that fiscal service officials erroneously made two duplicate payments to vendors. The VISN director took appropriate administrative action against the VAMC director and stated that custodial responsibility for the computer would be transferred to the director's new duty station.
- A Hotline-prompted VHA review found that information resources management service personnel improperly disposed of old computer equipment. The VAMC director took action to clarify responsibilities for condition-coding computer equipment and to enforce computer equipment disposition responsibilities. The review also revealed that the VAMC was not repairing computer equipment in the most cost-effective manner. The VAMC is determining the most cost-effective organization and procedures for maintaining and repairing computer hardware.

### **Appropriateness of Certain Timekeeping Procedures**

- A Hotline-prompted VISN review at a VAMC substantiated allegations of time and attendance abuse. Two employees left their work station before the end of their tour of duty without following proper leave requesting procedures. The employees were placed in an unpaid status for their absences. An additional allegation involving the overpayment of incentive pay to an employee was also substantiated. The overpayment was the result of a miscalculation of extra time worked. Corrective action was taken to collect \$162 from the employee.
- A Hotline inquiry resulted in a substantiated allegation of time and attendance abuse. An employee posted her timecard and the timecard of her husband for compensatory time on one occasion. The service chief, assistant service chief, and the employee were counseled about avoiding conflicts of interest in timekeeping responsibilities.

## **Veterans Benefits Administration**

### **Continuing Compensation Payments to Incarcerated Veterans**

A VBA review initiated by a Hotline inquiry found that a veteran was receiving full benefits while incarcerated. The veteran failed to notify the VARO of his incarceration that began in June 1998, resulting an overpayment of compensation benefits in excess of \$2,300. The VARO is taking action to collect the overpayment.

### **Failing to Report Incompetent Veteran's Income in Excess of \$1,500**

A VARO review in response to a Hotline inquiry found a fiduciary at fault for failing to report an incompetent veteran's income above \$1,500, as required by law, which establishes an income limitation for incompetent veterans hospitalized at Government expense. The review found a state veterans' home had knowledge of the law's requirements but failed to notify VA of the veteran's receipt of additional income. The regional office assessed the fiduciary for the \$24,000 overpayment.

### **Fiduciary Responsibilities**

A Hotline review by a VARO was unable to substantiate allegations of fraud by a fiduciary. However, the review did show that the incompetent veteran had poor living conditions. The VARO sent the fiduciary a letter citing the findings and requesting corrective action. The VARO will revisit the veteran to verify that his living conditions have improved.

### **Misuse of Government Equipment**

A VARO review in response to a Hotline inquiry did not substantiate an allegation that a VA employee destroyed Government property. However, the review determined that the employee used poor judgment in replacing a hard drive in a personal computer that was in perfect condition. The employee received an admonishment for negligence with Government equipment and records.

### **VA Insurance**

Responding to a Hotline inquiry, VBA confirmed that an improper authorization was made against a life insurance policy. The review found that a \$10,000 loan was issued against the wrong veteran's policy. VBA officials identified employee errors made in the



processing of the request. The records were corrected; VBA secured repayment from the veteran who received the funds in error.

## **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 search 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 the OIG.

The Data Analysis Section processed 566 requests for information received from OIG operational elements in the last six months. In conjunction with these requests, data analysis staff worked closely with auditors, inspectors, and investigators requesting information to ensure the data was valid, complete, and met their needs. The support work provided by data analysis staffs are shown in many of the projects and investigative cases described in the semi-annual report.

In addition, data analysis staff process requests from other Federal agencies, and other governmental organizations. The Data Analysis Section routinely receives requests from the Federal Bureau of Investigation, Department of Health and Human Resources, Air Force Office of Special Investigations, and other Department of Defense organizations. The following reflects some of the analysis and data collected for these groups.

### **Assistance to the FBI**

- The FBI sought our assistance in locating a former VA nurse involved in the sale of stolen Government computers. We provided the FBI with the nurse's last known address, bank account number, social security number, and other data in support of their investigation.

### **Assistance to the Department of Health and Human Services (HHS)**

- HHS sought our assistance on several occasions in their ongoing efforts to detect billing fraud. We provided investigators information pertaining to three health care providers who were suspected of submitting false billings. We also provided data in support of an investigation of health care providers that allegedly overcharged for services.
- HHS also requested assistance in obtaining VA payment information pertaining to several companies that allegedly altered invoices, certificates of necessity, altered diagnoses, and misrepresented the services provided.

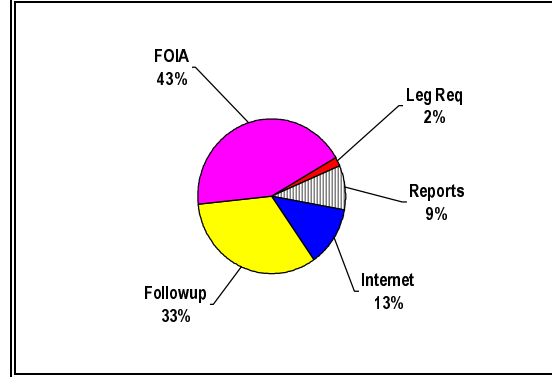
### **Assistance to VA Elements**

Data analysis staff also receive requests for assistance from VHA and VBA. To illustrate, data analysis staff assisted VHA and VBA in reviews of their accounts receivable during this period. VHA requested our office to upload accounts receivable records stored in our files to assist them in reconciling individual hospital accounts. VBA requested our assistance in uploading accounts receivable transactions pertaining to their 58 regional offices to enable them to correct large discrepancies noted in their accounts receivable balances.

### **Monitoring VA's Year 2000 Conversion**

Data analysis staff uncovered a Year 2000 computer-coding problem that warranted

management attention during this reporting period. While working with a Social Security Notice of Death File maintained by the Austin Automation Center, we discovered a file in which all of the people reported as having died in 1998 would be shown to have died in 1919 in the Year 2000. We advised VA Central Office of this Year 2000 computer dilemma and they corrected the coding problem for all SSA files before serious misinformation occurred.



## II. OPERATIONAL SUPPORT

### Mission Statement

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

### Resources

This Division has 9 FTE with the following allocation:

### Overall Performance

#### Followup on OIG Reports

The Division is responsible for obtaining implementation actions on audits, inspections, and reviews with over \$1.2 billion of actual or potential monetary benefits as of March 31, 1999. Of this amount \$1 billion is resolved, but not yet realized as VA has agreed to implement the recommendations, but has not yet done so. In addition, \$230 million relates to unresolved reviews awaiting contract resolution by VA contracting officers.

The Division is also responsible for maintaining the Department's 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 management are resolved as promptly as possible and that corrective actions are implemented as agreed upon by management officials. Disagreements unable to be resolved between OIG and management are decided by the Deputy Secretary, VA's audit followup official.

Management officials are required to provide the OIG with documentation showing the completion of corrective actions, including reporting of collection actions until the amounts

## Office of Management & Administration

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due VA are either collected or written off. OIG staff evaluates information submitted by management officials to assess both the adequacy and timeliness of actions and to request periodic updates on an ongoing basis.

As of March 31, 1999, VA had 117 open internal OIG reports with 313 resolved, but unimplemented, recommendations and 51 unresolved contract review recommendations which are awaiting contracting officer's decisions.

During this reporting period, the Division took action to close 48 internal reports issued in this and prior periods, with 169 recommendations and a monetary benefit of \$218 million, after obtaining information that showed management officials had fully implemented corrective actions.

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 137 requests under the Freedom of Information and Privacy Acts and released 202 audit, investigative, and other OIG reports. In two instances we had no records. We totally denied eight requests under the appropriate exemptions of the Acts. Information was partially withheld in 81 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, only 2 FOIA cases did not receive written responses within 20 working days, as required. Six complex cases were over one year old; five of these were from the same requester. The average processing time for workable FOIA requests coded as complex was 112 working days; for cases coded as routine, it was 13 working days.

### **Internet Technology**

The Division is responsible for processing and controlling electronic publication of OIG reports, including maintaining the OIG websites and posting OIG reports and information on the Internet. The OIG's public website received 1,256,000 hits from almost 70,000 visitors during this period.

The OIG frequent requests page is the most comprehensive and up to date of all pages in the VA's Electronic Reading Room. We now directly maintain this page to ensure that frequently-requested reports are available in a timely manner. We provided direct links to an

audit report and a healthcare inspection report, which were frequently requested during this period, along with our vacancy announcements. One frequently-requested OIG report was downloaded over 3,000 times from the OIG website. The vacancy announcements page received over 5,000 hits from 3,565 visitors during the last month of the reporting period. We also posted a number of unredacted reports, press releases, and recurring OIG publications such as the last Semiannual Report to the Congress.

We initiated further improvements in protecting our information assets by dedicating staff to information security and by participating in Department-level initiatives and policy development. We also provided input on security improvements on the Department's network replacement projects and to the Department's new Chief Information Officer.

### Review and Impact of Legislation and Regulations

The Division coordinated concurrences on legislative and regulatory proposals from the Congress, Office of Management and Budget, 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, 39 regulatory proposals, and 14 "other" proposals were reviewed and commented on, as appropriate.

## III. RESOURCES MANAGEMENT DIVISION

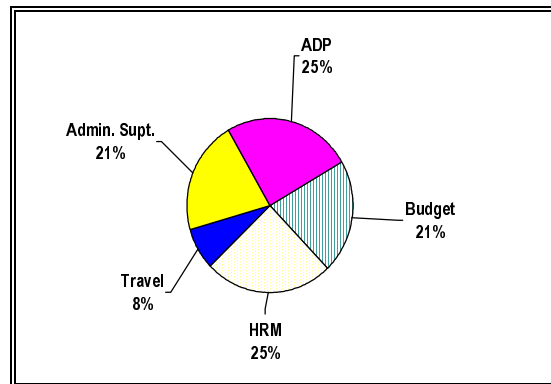
### Mission Statement

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

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

### Resources

The Resources Management Division has 14 FTE currently assigned to the OIG headquarters. The staff allocation for the five functional areas is as follows.



## **Overall Performance**

### **Automated Data Processing**

The OIG awarded a contract to convert the existing management information system from an outdated version of Oracle to an up-to-date version, which will provide similar functionality with a graphical user interface. In addition, we are incorporating a new case numbering system, additional search features, and some improved data validation functions. The new system will be Year 2000 compliant.

### **Budget**

The staff assisted in the coordination and preparation of the 2000 budget submission and materials for associated briefings and Congressional hearings. Numerous inquiries from the Office of Management and Budget and Congress were addressed, especially pertaining to the recent realignment and the utilization of additional personnel resources.

The staff executed 93 percent of the OIG's mid-year budget authority.

### **Human Resources Management**

During this period, the staff made significant progress in recruiting and hiring to an increased staffing level authorized for FY 1999. The staff also processed 76 personnel actions, 1 distinguished career award, 50 special contribution awards, 4 time-off awards, and 2 quality step increases.

### **Travel**

OIG personnel travel almost continuously. As a result, the Travel section processed 1,188 travel and 20 permanent change of station vouchers in addition to 8 amendments to existing permanent change of station authorities.

## **Administrative Support**

Due to the increased staffing and the realignment within the OIG, there are several relocation projects currently in progress. These projects involve 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 67 procurement actions and reviewed and approved each month the 38 statements received from the OIG's cardholders under the Government's purchase card program.

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# OTHER SIGNIFICANT OIG ACTIVITIES

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## **President’s Council on Integrity and Efficiency (PCIE)**

### **Federal Audit Executive Committee**

The Assistant Inspector General (AIG) for Auditing continued as the chairperson of the Committee. The purpose of the Committee is to discuss and coordinate on issues affecting the Federal audit community in general, and in particular, matters affecting audit policy and operations of common interest to members. In addition, the AIG for Auditing is the Federal audit community representative on the PCIE audit committee.

### **Inspections and Evaluations Roundtable**

The AIG for Healthcare Inspections works intensively with the PCIE Inspections and Evaluations Roundtable, providing leadership in developing a core skills inventory for Government inspectors and evaluators. The Deputy AIG serves as co-chair of the Inspection and Evaluation Roundtable’s Education and Training Subcommittee.

## **OIG Management Presentations**

### **Dallas/Fort Worth Chapter, Association for Government Accountants**

The AIG for Auditing provided a presentation on the “*Future of the Audit Community*” to the Chapter. He highlighted Federal Audit Executive Committee and PCIE initiatives, the crossroads that the Federal audit community is facing, and the actions federal auditors are taking to contribute to a better Government.

### **Presentation to House Veterans’ Affairs Committee**

At the request of the Committee, the OIG Counselor and managers in the Contract Review and Evaluation Division gave a presentation on the division activities. They pointed out that postaward review of VA’s Federal Supply Schedule contracts had returned about \$100 million to VA for the 5-year period starting in October 1993.

### **Presentation at the 1999 Acquisition Management Forum**

The OIG Counselor and Director, Contract Review and Evaluation Division gave a presentation on OIG issues related to contract review activities. The purpose of the 1999 Forum is to provide continuing education opportunities for contract specialists and officers.

### **Presentation at the 1999 Federal Healthcare Acquisition Conference**

The OIG Counselor and Director, Contract Review and Evaluation Division gave a presentation on lessons learned from OIG reviews. The conference was co-sponsored by the VA, Department of Defense, and the National Contract Management Association. About 600 professionals, representing both public and private sector organizations, attended the conference.

### **Presentation at the Coalition for Government Procurement**

The Director, Contract Review and Evaluation Division and OIG Counselor addressed recent Government efforts in enforcing contract compliance at the “Coalition’s Conference.” About 170 members, representing public and

## Other Significant OIG Activities

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private sector interests in contracting with the Government, attended the conference.

### **Presentation at George Washington University Law School Government Contracts Program**

The Director, Contract Review and Evaluation Division, gave a presentation regarding Federal Supply Schedule contract reviews and outcomes. The program was attended primarily by pharmaceutical industry representatives.

### **Presentation at the American Society of Military Surgeons**

A manager from the Contract Review and Evaluation Division spoke at an American Society of Military Surgeons meeting. Presentation topics included preaward and postaward reviews, commercial selling practices, defective pricing, price reduction, and the OIG role in VA's contracting program. A question and answer session followed the presentation.

### **Presentation to the Department of Defense**

The Director, Management, Policy, and Professional Development conducted a seminar on PCIE external quality control reviews to the Department of Defense.

### **International Symposium on Preventing Medical Errors**

Two senior Office of Healthcare Inspections employees participated in a panel on the occurrence of medical errors at an International Symposium on Preventing Medical Errors. The topic of the presentation was the occurrence, reporting, and prevention of medication errors.

### **Presentation to Leadership VA 1999**

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

### **OIG Congressional Testimony**

In February 1999, the Inspector General and the AIG for Auditing testified before the House Committee on Government Reform and Oversight, Subcommittee on National Security, Veterans Affairs, and International Affairs. The testimony addressed the major performance and management challenges facing VA. Highlighted were the contributions of the OIG in combating waste, fraud, and abuse in VA programs and administrative activities.

In March 1999, the Inspector General and the AIG for Auditing testified before the House Committee on Veterans Affairs, Subcommittee on Oversight and Investigations. The hearing focused on the VA's management of the Federal Employees' Compensation Act, also known as the Worker's Compensation Program. The testimony presented the significant audit and investigative activity conducted by the OIG to root out fraud and mismanagement, improve case management, and reduce costs.

In March 1999, the Inspector General and the AIG for Management and Administration testified before the House Committee on Veterans Affairs, Subcommittee on Oversight and Investigations. The testimony addressed the policies and protections of the OIG for employees who engage in whistleblowing activities, as well as for other employees who may be subjected to retaliation for filing various types of claims or complaints against VA.

## **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, 14 subpoenas were issued in conjunction with various OIG investigations and audits.



## Other Significant OIG Activities

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# 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		Questioned Costs
		OIG	Management	

### **COMBINED ASSESSMENT PROGRAM**

9IGCAP501 3/31/99	Combined Assessment Program Project VAMC Martinsburg, WV
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### **INTERNAL AUDITS**

9R5D02007 10/23/98	Audit of Surgical Suite Renovation Project at Department of Veterans Affairs Medical Center Fresno, CA	\$126,000	\$126,000
9D2A19001 1/12/99	Audit of Veterans Integrated Service Network (VISN 10) Organization, Planning, and Implementation of Key Strategic Goals and Objectives		
9R5D02032 1/29/99	Audit of Ambulatory Care Renovation Project at Department of Veterans Affairs Medical Center Atlanta, GA		
9R3E99037 2/12/99	Audit of the Department of Veterans Affairs Purchase Card Program	\$22,000,000	\$22,000,000
9R8E04052 3/9/99	Audit of VA Medical Center Management of Medical Supply Inventories	\$75,600,000	\$75,600,000
9AFG10061 3/10/99	Report of Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Year 1998		
9R4A19075 3/31/99	Audit of Veterans Health Administration Decision Support System Standardization	\$140,000,000*	\$140,000,000*

\* Implementation of the agreed-upon action plan will justify system costs and result in the system fulfilling its potential.

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

### **OTHER OFFICE OF AUDIT REVIEWS**

9R5B01005 10/15/98	Accuracy of Data Used to Measure Claims Processing Timeliness			
9ANG01003 10/27/98	Observations on the VA Franchise Fund Financial Operations for Fiscal Year 1997			
9R8E11008 10/30/98	Evaluation of VA Medical Center Clinical Services Contracts with Medical Schools			
9R1B18012 11/25/98	Review of Education Service's Quality Review System			
9AFG10018 12/9/98	Management Letter – ADP Security at Southwest Healthcare Network			
9AFG01016 12/16/98	Agreed-Upon Procedures: Retirement, Health, and Life Insurance Withholdings/Contributions and Supplemental Semiannual Headcount Report			
9R8A06021 12/31/98	Evaluation of Allegations Concerning Selected Fee Services Activities at the Jerry L. Pettis Memorial VA Medical Center Loma Linda, CA			
9R3B01031 2/5/99	Evaluation of Benefit Payments to Incarcerated Veterans	\$170,000,000	\$170,000,000	
9R1B18044 2/24/99	Review of Vocational Rehabilitation and Counseling Service's Quality Review System			
9R1G01054 3/15/99	Evaluation of VHA's Income Verification Match Program	\$18,026,448	\$18,026,448	
9AFG10068 3/17/99	ADP Security at Carl T. Hayden Medical Center			
9R1G01063 3/24/99	Review of Medical Insurance Billing Practices at VAOPC Sepulveda, CA			
9R5B10047 3/25/99	Attributes of Defaulted VA Home Loans			
9AFG10066 3/26/99	Management Letter: Accuracy of Fiscal Year 1998 Property, Plant, and Equipment Financial Information			
9AFG10065 3/29/99	Management Letter: Accuracy of Department of Veterans Affairs' Payroll Data for Fiscal Year 1998			

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

### **OTHER OFFICE OF AUDIT REVIEWS (Con't)**

9AFG10067 Management Letter: Accuracy of Fiscal Year 1998  
3/31/99 Medical Facility Accounts Receivable Financial  
Information

9AYA19078 Evaluation of Medical Center Investment in  
3/31/99 Ambulatory Care Infrastructure

### **CONTRACT REVIEWS \***

9PEX20010 Report of Survey – American Regent Laboratories'  
11/6/98 Implementation of Section 603 Drug Pricing  
Provisions of Public Law 102-585

9PEX04009 Review of Federal Supply Schedule Proposal \$170,000  
11/12/98 (Solicitation Number M3-Q4-97), Sterling Diagnostic  
Imaging, Inc., Newark, DE

9PEX04004 Review of Federal Supply Schedule Proposal \$20,640,526  
11/30/98 (Solicitation Number M3-Q4-97), Eastman Kodak  
Company, Rochester, NY

9PEX09013 Review of Federal Supply Schedule Proposal  
11/30/98 (Solicitation Number M6-Q5-98), Hill-Rom  
Company, Inc., Batesville, IN

9PEX18020 Postaward Review of Federal Supply Schedule \$71,536  
12/31/98 Contract V797P-3903j, Carl Zeiss, Inc., Thornwood,  
NY

9PEX20027 Survey of Biogen, Inc.'s Public Law 102-585, Section  
1/25/99 603 Policies and Procedures

9PEX20030 Survey of Agouron Pharmaceutical, Inc.'s Public Law  
1/26/99 102-585, Section 603 Policies and Procedures

9PEX01022 Review of Federal Supply Schedule Proposal \$2,409,502  
2/4/99 (Solicitation No. M5-Q50-97), Baxter Healthcare  
Corporation, Deerfield, IL

9PEX20033 Survey of Astra Pharmaceuticals, L.P.'s (Formerly \$167,352  
2/4/99 Known as Astra USA, Inc.) Public Law 102-585,  
Section 603 Policies and Procedures

\* 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		Questioned Costs
		OIG	Management	

### **CONTRACT REVIEWS (Con't)**

9PEX20040 2/17/99	Report of Survey – Pasteur Merieux Connaught's Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585			
9PEX18024 2/22/99	Postaward Review of Federal Supply Schedule Contract V797P-3622j, Angelica Image Apparel, St. Louis, MO			\$14,337
9PEE02036 2/23/99	Review of Federal Supply Schedule Proposal (Solicitation Number M3-QF-98), Everest & Jennings, Earth City, MO	\$680,400		
9PEX20046 2/25/99	Survey of Berlex Laboratories' Public Law 102-585, Section 603 Policies and Procedures			
9PEX20050 3/1/99	Review of Schein Pharmaceutical, Inc.'s Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Number V797P-5548m			\$60,780
9PEX20053 3/11/99	Review of Athena Neurosciences, Inc. Implementation of Section 603 Drug Pricing Provisions of Public Law Under Federal Supply Schedule Contract Numbers V-797P-5161x and V-797P-5762n			\$46,685
9PEX11082 3/11/99	Settlement Agreement – Postaward Review of Ciba- Geigy (Novartis) Corporation			\$8,000,000
9PEX20056 3/15/99	Review of 3M Pharmaceuticals Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Number V797P-5512m			\$191,819
9PEX09055 3/17/99	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97), Kerr Corporation, Orange, CA			
9PEX20076 3/31/99	Review of Astra Pharmaceuticals, L.P. (Formerly Known as Astra Merck, Inc.) Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Numbers V797P-5853n and V797P-5134x			\$4,204

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

### **ADMINISTRATIVE INVESTIGATIONS**

9PRA03015 1/20/99	Ethical Conduct Issues VA Medical Center Memphis, TN			
9PRD03026 2/2/99	Conduct Issues Concerning a Senior Official, Alvin C. York VA Medical Center at Murfreesboro, TN			\$5,000
9PRG03035 2/12/99	Administrative Investigation: Conduct and Personal Property Issues, VA New Jersey Health Care System, Lyons Division, New Jersey			
9PRA99043 3/3/99	Administrative Investigation: Gambling, Time and Attendance, and Other Issues, VA Medical Center Biloxi, MS			
9PRA19045 3/16/99	Administrative Investigation: Misuse of Position and Misuse of Resources Issues, VA Palo Alto Health Care System, Palo Alto Division			
9PRA99059 3/25/99	Administrative Investigation: Travel, Vehicle Use, and Contracting Issues at the Mid-Atlantic Veterans Integrated Service Network Durham, NC			
9PRA18073 3/30/99	Administrative Investigation: Credit Union Checking Account Issues, VA Central Office Chaplain Service, Hampton, VA			
9PRA19074 3/30/99	Administrative Investigation: Loss of VA Property and Inappropriate Purchase Issues, VA Medical Center Long Beach, CA			

### **HEALTHCARE INSPECTIONS**

9HIA28006 10/23/98	Inspection of Alleged Mismanagement of Fee-Basis Program and Patient Mismanagement, Department of Veterans Affairs Medical Center San Juan, PR			
9HIF03011 11/9/98	Quality Program Assistance Review Department of Veterans Affairs Medical Center San Juan, PR			
9HIA28017 12/8/98	Inspection of Alleged Inadequate Informed Consent for Surgery, James A. Haley Veterans' Hospital Tampa, FL			
9HIA28019 12/16/98	Inspection of Five Adverse Patient Care Events at the Department of Veterans Affairs Medical Center Miami, FL			

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

### HEALTHCARE INSPECTIONS (Con't)

9HIA28023 1/7/99	Inspection of Alleged Nursing Non-Attendance, Lack of Compassion, and Verbal Abuse			
9HIA28025 1/11/99	Inspection of Search Procedures for an Allegedly Missing Patient, Department of Veterans Affairs Central Alabama Health Care System Tuskegee, AL			
9HIA06014 1/25/99	Evaluation of the Veterans Health Administration's State Veterans Homes Inspection Process			
9HIA28028 1/26/99	Inspection of Alleged Inadequate Medical Care, James A. Haley Veterans' Hospital Tampa, FL			
9HIA28029 1/29/99	Inspection of Alleged Inadequate Psychiatric Nurse Staffing, VA Northern Indiana Health Care System, Marion Division, Marion, IN			
9HIA28034 2/2/99	Inspection of Multiple Allegations of Improper Medical and Psychiatric Care for Long-Term Care Patients, Veterans Affairs Puget Sound Health Care System, American Lake Division			
9HIA28038 2/10/99	Inspection of Alleged Lack of Quality of Care Department of Veterans Affairs Medical Center New Orleans, LA			
9HIA28041 2/12/99	Inspection of Alleged Substandard Patient Care in the Arizona State Veterans Home, Phoenix, AZ			
9HIA28039 2/17/99	Inspection of Patient Care Allegations and Quality Program Assistance Review, Department of Veterans Affairs Medical Center Togus, ME			
9HIA28042 2/18/99	Evaluation of Quality Management Structure and Resources in the Department of Veterans Affairs Veterans Health Administration			
9HIA28048 2/26/99	Inspection of Alleged Failure to Provide Surgery and Appropriate Medical Care Department of Veterans Affairs Medical Centers, Little Rock and Fayetteville, Arkansas			
9HIA28051 3/2/99	Oversight Evaluation of the Veterans Health Administration's Implementation of its Patient Safety Improvement Policy in Two Sentinel Events			

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

**HEALTHCARE INSPECTIONS (Con't)**

9HIA28062 3/17/99 Inspection of Alleged Multiple Clinical and Administrative Deficiencies on Long-Term Care; a Focus Review of Nursing Unit 8a; and a Quality Program Assistance Review, Department of Veterans Affairs Medical Center Northport, NY

9HIA28069 3/18/99 Inspection of Alleged Cover Up of a Patient's Death, VA Medical Center Dayton, OH

9HIA28077 3/29/99 Inspection of Quality of Care Allegations, Department of Veterans Affairs Medical Center Boston, MA

9HIA28079 3/30/99 Inspection of Alleged Poor Quality of Care, Department of Veterans Affairs Medical Center West Los Angeles, CA

**TOTAL: 72 Reports \*\$449,652,876 \*\$425,752,448 \$8,561,713**

\* The difference between the OIG and Management estimates is \$23,900,428. This entire difference is based on the pending receipt of the contracting officer's decision.





## APPENDIX B

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use	Unsupported Costs
8PEN03128 10/13/98	Proposal, RFP 521-057-98 (EP) Construction, VAMC Birmingham, Urrutia, Inc., Abbeville, AL		
8PEN02109 10/27/98	Proposal, Project No. 644-014, Construct Conference Ctr, VAMC Phoenix, Huber Hunt and Nichols, Phoenix, AZ		
8PEN02110 10/27/98	Claim, Project No. 549-085/031, A/E, VAMC Dallas, Dahl Architects, Inc./F&S Partner, Inc., Dallas, TX		
9PEN02101 12/06/98	Claim, Project No. 600-099, Correct Deficiencies, VAMC Long Beach, AC Martin Partners, Los Angeles, CA		
8PEN03130 01/06/99	Proposal, RFP 69d-366-98, Upgrade Ambulatory Surgery, VACSC Milwaukee, Oakley Construction Company, Inc., Chicago, IL		
8PEN03131 01/06/99	Proposal, RFP 690-367-98, Asbestos Abatement, VACSC Milwaukee, Enviroplus, Inc., Evanston, IL		
8PEN03129 01/08/99	Proposal, RFP No. 69d-365-98, Renovate Ambulatory Care, VAMC Lakeside, Alvarez/Mota Joint Venture, East Dundee, IL		
8PEN02008 02/17/99	Proposal, Contract No. V101ac0066, Construction, VAMC Northport, Carter Steel & Fabricating Company, Bellefontaine, OH	\$40,500	\$498,378
8PEN02014 02/17/99	Proposal, Project No. 672pm2083, A/E, VAMC San Juan O'kon & Company, Inc., Atlanta, GA		
5PEN02307 02/18/99	Claim, Project No. 580-040, Electrical, VAMC Houston, TX, Centex Bateson Construction Co., Inc., Dallas, TX	\$3,280,340	
<b>TOTALS:</b>	<b>10 Reports</b>	<b>\$3,320,840</b>	<b>\$498,378</b>

The Defense Contract Audit Agency completed all the 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, 1999

<u>Report Title, Number, and Issue Date</u>	<u>Questioned Costs</u>	<u>Recommended Better Use of Funds</u>	<u>Reason for Delay and Planned Date for a Decision</u>
<b>Contract Reviews by OIG</b>			
<b><u>OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT</u></b>			
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); No planned decision date available.
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; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Schering Corporation, Union, NJ, 8PE-E02-024, 10/17/97		\$92,037,146	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Ortho Pharmaceutical Corporation, Raritan, NJ, 8PE-E02-015, 10/20/97		\$17,084,449	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Smithkline Beecham, Philadelphia, PA, 8PE-E02-029, 10/21/97		\$1,266,297	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Eli Lilly and Company, Indianapolis, IN, 8PE-E02-016, 10/22/97			Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Abbott Laboratories Hospital Products Division, Abbott Park, IL, 8PE-E02-038, 11/5/97		\$5,932,784	Pending receipt of Contracting Officer PNM; No planned decision date available.

<u>Report Title, Number, and Issue Date</u>	<u>Questioned Costs</u>	<u>Recommended Better Use of Funds</u>	<u>Reason for Delay and Planned Date for a Decision</u>
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**OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT (Con't)**

Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-92), Graphic Controls Corporation, Buffalo, NY, 8PE-E02-063, 1/26/98		\$294,535	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), McGaw Incorporated, Irvine, CA, 8PE-E02-064, 2/9/98		\$9,207,294	Pending receipt of Contracting PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97), Gendex Dental X-Ray, Division of Dentsply International, Inc., Des Plaines, IL, 8PE-E02-074, 3/4/98		\$91,969	Pending receipt of Contracting Officer PNM; No planned decision date available.
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; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-92, Open Season IV) Howmedica, Inc., Pfizer Hospital Products Group Rutherford, NJ, 8PE-E02-081, 3/23/98		\$3,126,441	Pending receipt of Contracting Officer PNM; No planned decision date available.
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.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97), Midwest Dental Products Corporation (a Wholly Owned Subsidiary of Dentsply International, Inc.), Des Plaines, IL, 8PE-E02-089, 3/31/98			Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q4-97), Bayer Corporation, AGFA Division, Ridgefield Park, NJ, 8PE-E02-098, 5/1/98		\$2,136,157	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Organon, Inc., West Orange, NJ, 8PE-E02-100, 5/15/98		\$784,625	Pending receipt of Contracting Officer PNM; No planned decision date available.

<u>Report Title, Number, and Issue Date</u>	<u>Questioned Costs</u>	<u>Recommended Better Use of Funds</u>	<u>Reason for Delay and Planned Date for a Decision</u>
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**OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT (Con't)**

Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97), Star Dental, Lancaster, PA, 8PE-E02-109, 6/3/98		\$1,695,678	Pending receipt of Contracting Officer PNM; No planned decision date available.
Audit of Termination Settlement Proposal and Claims for Equitable Adjustment Submitted by Bar-Con Corporation Contract V523C-1129, 8PE-D03-112, 6/24/98		\$333,886	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97), Kavo America Corporation, Lake Zurich, IL, 8PE-E02-114, 6/24/98			Pending receipt of Contracting Officer PNM; No planned decision date available.
Audit of Claim for Alleged Damages Under an Agreement with a VAMC, 8PE-A12-104, 7/1/98		\$318,008	Pending receipt of Contracting Officer PNM; 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		\$9,340,040	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97), Nobel Biocare USA, Inc., Westmont, IL, 8PE-X06-148, 9/30/98		\$87,425	Pending receipt of Contracting Officer PNM; No planned decision date available.

<u>Report Title, Number, and Issue Date</u>	<u>Recommended Better Use of Funds</u>	<u>Unsupported Costs</u>	<u>Reason for Delay and Planned Date for a Decision</u>
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**Contract Reviews by Other Agencies**

**OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT**

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; no planned resolution date available.
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 appeal; planned resolution date not 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		Negotiation not finalized; no planned resolution date available.

**OFFICE OF FACILITIES MANAGEMENT**

Change OR/FR 10 Contract No. V101BC0053 VAMC Atlanta, GA Caddell Contraction Masterclean, Incorporated, Decatur, GA, 3PE-N02-111, 11/16/93	\$126,130		Negotiation not finalized; resolution planned for next reporting period.
Adjustment Claim, V101C-1606, Construction Service, VAMC Albany, Bhandari Constructors Inc., Syracuse, NY, 5PE-N02-007, 3/31/95	\$271,599		Negotiation not finalized; no planned resolution date available.
Claim, Contract No. V101C-1651, Environment Improvement, VAMC North Chicago, Blount Inc. 4PE-N02-202, 2/7/96	\$7,370,861		Negotiation not finalized; no planned resolution date available.
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. 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		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; no planned resolution date available.
Claim, Contract No. V101C-1603, Install Sprinklers, VAMC Boston, L. Addison & Associates, Inc., Wakefield, MA, 6PE-N02-108, 12/19/96	\$1,120,170		Negotiation not finalized; no planned resolution date available.

<u>Report Title, Number, and Issue Date</u>	<u>Recommended Better Use of Funds</u>	<u>Unsupported Costs</u>	<u>Reason for Delay and Planned Date for a Decision</u>
<b><u>OFFICE OF FACILITIES MANAGEMENT (Con't)</u></b>			
Claim, Project No. 690-035 MFI Addition, VAMC Brockton, Saturn Construction Co., Inc., Valhalla NY, 6PE-N02-001, 5/19/97	\$724,755		Negotiation not finalized; no planned resolution date available.
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; no planned resolution date available.
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; no planned resolution date available.
Proposal, Project No. 508-018A Clinical Addition, VAMC Atlanta, Caddell Construction Company, Montgomery, AL, 8PE-N02-005, 8/6/98	\$17,565		Negotiation not finalized; no planned resolution date available.

**OFFICE OF THE GENERAL COUNSEL**

Claim, Contract No. V539C-591, Install Incinerator, VAMC Cincinnati R.E. Schweitzer Construction, Cincinnati, OH 4PE-N03-113, 6/21/94	\$131,932		Contract in litigation; no planned resolution date available.
Claim, Contract No. V657C-1103; Replace HVAC VAMC St. Louis, Gross Mechanical Contractors Inc., St. Louis, MO, 6PE-N03-119, 10/24/96	\$90,437		Claim in litigation; no planned resolution date available.



<u>Report Title, Number, and Issue Date</u>	<u>Recommended Better Use of Funds</u>	<u>Unsupported Costs</u>	<u>Reason for Delay and Planned Date for a Decision</u>
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**OFFICE OF VETERANS HEALTH ADMINISTRATION**

A-128, Fiscal Year Ended 6/30/96, State Approving Agency Contract, State Home Construction & Nursing Home Care, State of Idaho, Boise, ID, 8PE-G06-046, 1/7/98

Negotiation not finalized; planned completion date could not be provided.

A-128, Fiscal Year Ended 6/30/95, State Approving Agency Contract, State Home Construction & Nursing Home Care, State of Idaho, ID, 7PE-G06-058, 1/8/98

Negotiation not finalized; planned completion date could not be provided.

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.

A-128, Fiscal Year Ended 6/30/96, Construction of State Home Facilities, State of Mississippi, Jackson, MS, 8PE-G06-079, 7/28/98

Negotiation not finalized; planned completion date could not be provided.

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## APPENDIX D

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### 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 March 31, 1999. 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 the period October 1, 1998 – March 31, 1999. The dollar figures used throughout this report are based on the definitions included in the IG Act Amendments of 1988. The figures are current as of March 31, 1999, and may reflect changes from the data in the individual reports due to OIG validation to ensure compliance with the IG Act Amendments definitions.

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**TABLE 1 - SUMMARY OF UNRESOLVED AUDIT REPORTS**

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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	42
	Contract Review	42	
Less Than 6 Months	Internal Audit	0	8
	Contract Review	8	
<b>TOTAL</b>			<b>50</b>

Tables 2 and 3 show a total of 40 reports that were unresolved as of March 31, 1999. This number differs from the 50 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.

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**TABLE 2 - RESOLUTION STATUS OF REPORTS WITH QUESTIONED COSTS**

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

<b>RESOLUTION STATUS</b>	<b>NUMBER OF REPORTS</b>	<b>QUESTIONED COSTS (In Millions)</b>
No management decision by 9/30/98	0	\$0
Issued during reporting period	9	\$8.6
<b>Total Inventory This Period</b>	<b>9</b>	<b>\$8.6</b>
Management decision during reporting period		
Disallowed costs	9	\$8.6
Allowed costs	0	\$0
<b>Total Management Decisions This Period</b>	<b>9</b>	<b>\$8.6</b>
<b>Total Carried Over to Next Period</b>	<b>0</b>	<b>\$0</b>

**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.

<b>RESOLUTION STATUS</b>	<b>NUMBER OF REPORTS</b>	<b>RECOMMENDED FUNDS TO BE PUT TO BETTER USE (In Millions)</b>
No management decision by 9/30/98	49	\$245.4
Issued during reporting period	12	\$453.4
<b>Total Inventory This Period</b>	<b>61</b>	<b>\$698.8</b>
Management decisions during reporting period		
Agreed to by management	11	\$441.0
Not agreed to by management	10	\$31.5
<b>Total Management Decisions This Period</b>	<b>21</b>	<b>\$472.5</b>
<b>Total Carried Over to Next Period</b>	<b>40<sup>1</sup></b>	<b>\$226.3</b>

<sup>1</sup> Of the 40 reports carried over, a management decision had not been made for over 6 months on 35 reports with a dollar value of \$201.8 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.



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## APPENDIX E

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### REPORTING REQUIREMENTS OF THE INSPECTOR GENERAL

The table below cross-references the reporting requirements 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), to the specific pages where they are addressed.

<b><u>IG Act References</u></b>	<b><u>Reporting Requirement</u></b>	<b><u>Page</u></b>
Section 4 (a) (2)	Review of legislation and regulations	67
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-68
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-68
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	89
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	i
Section 5 (a) (5)	Summary of instances where information was refused	71
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	73-81 (App. A & B)
Section 5 (a) (7)	Summary of each particularly significant report	i to vi
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	90 (Table 2)
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	91 (Table 3)
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	83 to 88 (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



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## APPENDIX F

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### VA FIELD OPERATIONS

#### Investigations

<b>Northeast Field Office (51NY) New York, NY</b> .....	212 807-3444
Boston Resident Agency (51BN) Boston, MA .....	781 687-3138
Newark Resident Agency (51NJ) Newark, NJ.....	973 645-3590
Washington, DC Resident Agency (51WA) Washington, DC.....	202 565-8079
<b>Southeast Field Office (51SP) Bay Pines, FL</b> .....	727 398-9559
Atlanta Resident Agency (51AT) Atlanta, GA .....	404 347-7869
Columbia Resident Agency (51CS) Columbia, SC .....	803 695-6707
New Orleans Resident Agency (51NO) New Orleans, LA .....	504 619-4340
West Palm Beach Resident Agency (51WP) West Palm Beach, FL.....	561 882-7720
<b>Central Field Office (51CH) Chicago, IL</b> .....	708 202-2676
Dallas Resident Agency (51DA) Dallas, TX .....	214 655-6022
Houston Resident Agency (51HU) Houston, TX .....	713 794-3652
Kansas City Resident Agency (51KC) Kansas City, KS .....	913 551-1439
<b>Western Field Office (51LA) Los Angeles, CA</b> .....	310 268-4268
Phoenix Resident Agency (51PX) Phoenix, AZ.....	602 640-4684
San Francisco Resident Agency (51SF) Oakland, CA.....	510 637-1074

#### Audit

<b>Central Office Operations Division (52CO) Washington, DC</b> .....	202 565-4433
<b>Contract Review and Evaluation Division (52C) Washington, DC</b> .....	202 565-4818
<b>Financial Management Audit Division (52CF) Washington, DC</b> .....	202 565-7913
Austin Residence (52AU) Austin, TX.....	512 326-6216
<b>Operations Division Atlanta (52AT) Atlanta, GA</b> .....	404 347-7790
<b>Operations Division Boston (52BN) Boston, MA</b> .....	781-687-3120
Philadelphia Residence (52PH) Philadelphia, PA.....	215 381-3052
<b>Operations Division Chicago (52CH) Chicago, IL</b> .....	708 202-2667
<b>Operations Division Kansas City (52KC) Kansas City, MO</b> .....	816 426-7100
Dallas Residence (52DA) Dallas, TX .....	214 655-6000
<b>Operations Division Seattle (52SE) Seattle, WA</b> .....	206 220-6654
Los Angeles Residence (52LA) Los Angeles, CA.....	310 268-4336





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## APPENDIX G

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### GLOSSARY

A&MM	Acquisition and Materiel Management
ADP	Automated Data Processing
AIG	Assistant Inspector General
BATF	Bureau of Alcohol, Tobacco, and Firearms
C&P	Compensation & Pension
CAP	Combined Assessment Program
CDR	Cost Distribution Report
CFS	Consolidated Financial Statements
DCIS	Defense Criminal Investigative Service
DIC	Dependency and Indemnity Compensation
DOL	Department of Labor
DSS	Decision Support System
FBI	Federal Bureau of Investigation
FOIA	Freedom of Information Act
FSS	Federal Supply Schedule
FTE	Full Time Equivalent
FY	Fiscal Year
GPRA	Government Performance and Results Act
HCA	Housing Credit Assistance
HEC	Health Eligibility Center
HHS	Department of Health and Human Services
IPA	Intergovernmental Personnel Act [assignment]
IT	Information Technology
IVM	Income Verification Match
NCA	National Cemetery Administration
NHCU	Nursing Home Care Unit
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
PCIE	President's Council on Integrity and Efficiency
PNM	Price Negotiation Memorandum
QM	Quality Management
QPA	Quality Program Assistance [Review]
RFP	Request for Proposal
RRB	Railroad Retirement Board
SAR	Semiannual Report [to Congress]
SMS	Scarce Medical Specialist
SSA	Social Security Administration
SVH	State Veterans Homes
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VAOPC	VA Outpatient Clinic
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VR&C	Vocational Rehabilitation and Counseling
WCP	Workers' Compensation Program

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Joseph M. Vallowe, Esq.  
VA OIG, Washington, DC

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**Department of Veterans Affairs  
Office of Inspector General  
Semiannual Report**

**October 1, 1998 - March 31, 1999**