Office of Inspector General

Semiannual Report to Congress

April 1, 1999 – September 30, 1999

FOREWORD

I am pleased to submit the semiannual report on the activities of the Office of Inspector General (OIG) for the period ended September 30, 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 $219 million in monetary benefits, for an OIG return on investment of $10 for every dollar expended. A noteworthy accomplishment was our evaluation of internal controls in the Compensation and Pension (C&P) benefit program that provided the Under Secretary for Benefits a comprehensive assessment of vulnerabilities in the general internal control environment, and C&P claims processing in particular. Additional OIG accomplishments during the period included 143 indictments, 83 criminal convictions, and 202 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 the Veterans Health Administration's (VHA's) management of confused and wandering patients, and the effectiveness of the joint VHA and Department of Defense collaborative traumatic brain injury program. Healthcare inspectors conducted proactive reviews of essential aspects of VHA clinical operations and patient treatment processes and made recommendations for improvement.

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

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

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

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HIGHLIGHTS OF OIG OPERATIONS

This semiannual report highlights the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for the 6-month period ended September 30, 1999. The following statistical data highlights OIG activities and accomplishments during the reporting period.

DOLLAR IMPACT	Dollars in Millions
Funds Put to Better Use	$209.9
Dollar Recoveries	$4.1
Fines, Penalties, Restitutions, and Civil Judgments	$5.9
RETURN ON INVESTMENT	
Dollar Impact ($219.9) / Cost of OIG Operations ($21.0)	10 : 1
OTHER IMPACT	
Indictments	143
Convictions	83
Administrative Sanctions	202
ACTIVITIES	
Reports Issued	
Combined Assessment Program	3
Audits	27
Contract Reviews	43
Healthcare Inspections	19
Administrative Investigations	10
Investigative Cases	
Opened	240
Closed	138
Hotline Activities	
Contacts	7,289
Cases Opened	396
Cases Closed	358

COMBINED ASSESSMENT PROGRAM

Three Combined Assessment Program (CAP) reports were issued during this reporting period. The CAP provides recurring cyclical oversight of VA medical facility operations, focusing on the effectiveness and quality of service provided to veterans. The program combines the skills and abilities of the OIG's major components to provide collaborative assessments of VA medical facilities. Each team consists of representatives from the Offices of Investigations, Audit, and Healthcare Inspections. They provide an independent and objective assessment of key operations and programs at VA medical centers on a cyclical basis.

OFFICE OF INVESTIGATIONS

During the semiannual period, the Office of Investigations, comprised of a Criminal Investigations Division and an Administrative Investigations Division, focused its resources on investigations that have the highest impact on the programs and operations of the Department. Criminal investigative priority continues to target cases of 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. Additionally, we began a major initiative with other components of the OIG to proactively identify fraud occurring in the programs of the Veterans Benefits Administration (VBA). During the period, the Criminal Investigations Division concluded 138 investigations resulting in 226 judicial actions and over $11.7 million recovered or saved. Investigative activities resulted in monetary benefits of over $12 returned to the Government for each dollar spent. The Administrative Investigations Division concentrated its resources in the investigation of allegations, generally against high-ranking VA officials, concerning misconduct and other matters of interest to the Congress and the Department. The division completed 15 administrative investigations this semiannual period and issued 10 reports. These investigations resulted in administrative action taken against 8 high-ranking officials and other employees, and 22 corrective actions taken by management to improve VA operations and activities.

Veterans Health Administration

The following are examples of investigations in which Veterans Health Administration (VHA) employees and contractors have been charged with various illegal activities: (i) A VA medical center (VAMC) nurse was arrested and subsequently indicted on charges of tampering with consumer products. Investigation disclosed the individual used syringes to withdraw Demerol from vials for his personal use, refilled the vials with saline solution, and returned them for distribution to veteran patients. The individual admitted his actions during the course of the investigation. (ii) A VAMC licensed practical nurse was sentenced to 5 months' imprisonment, 5 years' supervised release, and was ordered to pay restitution of $33,350. He stole personal checkbooks from two veteran patients at the VAMC and wrote checks to himself by forging the veterans' signatures. (iii) A veterans outreach specialist was sentenced to 12 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $324,700. For almost 13 years, the individual collected Workers' Compensation benefits, claiming 100 percent disability from on-the job-injury. During the time he was collecting benefits for his inability to work, he was, in fact, working a series of paying jobs. (iv) A contractor who supplied surgical instruments to VA agreed to pay $1,334,000 to the Government after being charged with violation of the False Claims Act. The contractor certified that they would supply VA surgical instruments manufactured in Germany. Instead, the company shipped imported surgical instruments made in non-designated countries. (v) A VA contractor who supplied tools and supplies to VAMCs was sentenced to 73 months in prison for conspiring to defraud VA and the Department of Defense (DoD) on Government contracts. He admitted that he paid bribes to VA officials in order to influence the awarding of approximately 190 VA contracts to his companies.

Veterans Benefits Administration

The following investigations are examples of fraud relating to some of the benefits programs administrated by VBA: (i) An individual was sentenced to 78 months' imprisonment and restitution of $571,000 after conviction on charges of equity skimming, mail fraud, bankruptcy fraud, and money laundering. The individual fraudulently assumed 61 properties with mortgages guaranteed by VA or insured by the Department of Housing and Urban Development (HUD), rented the homes, and kept the

rent monies for himself without making the required mortgage payments. His actions caused all of the loans to go into default and foreclosure. He delayed foreclosure proceedings by filing multiple bankruptcies under fictitious names. (ii) A former VA regional office (VARO) ratings specialist was sentenced to 33 months' imprisonment and was ordered to pay restitution of $588,872 after pleading guilty to stealing VA compensation benefits. He created a record for a fictitious veteran and awarded the fictitious veteran benefits for service connected disabilities. For more than 12 years he caused VA to deposit over $588,000 in monthly benefit checks into a savings account opened in the name of the fictitious veteran. (iii) A VARO supervisor was sentenced to 33 months' in prison, ordered to pay restitution of $615,000, and forfeit more than $300,000 in personal property. A VARO senior claims examiner was also charged in the case. Investigation disclosed the two conspired to create records, which fraudulently reflected that the supervisor's fiancé was entitled to receive more than $615,000 in disability payments to which he was not entitled. (iv) An individual was indicted on one count of forgery after he concealed his mother's death for almost 9 years in order to continue receiving more than $78,000 in VA Dependency and Indemnity Compensation (DIC) benefits in her name. (v) An individual was sentenced to 8 months' imprisonment, 36 months' probation, and ordered to pay restitution of $59,780 following a guilty plea to charges of fraud against the Government. He fraudulently received VA benefits for a service-connected disability by declaring himself unable to work. At the same time he was working under a false name and Social Security number to conceal the fraud. (vi) An individual was indicted and arrested on charges of health care fraud, false use of a Social Security number, and theft of Government funds. The individual, who was not a veteran, assumed the identity of a veteran, utilized the identifying data of the veteran, and filed fraudulent documents in order to receive VA medical treatment and pension benefits totaling more than $147,000. (vii) The spouse of a veteran was sentenced to 12 months' home confinement, 2 years' supervised release, and ordered to pay restitution of $243,044 after pleading guilty to theft of Government funds. She failed to report her husband's death and, for more than 15 years, continued to collect VA disability benefits sent in the husband's name, totaling more than $243,000. (viii) An individual acting as a VA fiduciary, court-appointed guardian, and Social Security representative payee to a number of elderly veterans was sentenced to 37 months' imprisonment, 3 years' probation, and ordered to pay restitution of $200,000 after pleading guilty to charges of misapplication of funds by a VA fiduciary and mail fraud. She appropriated funds belonging to the estates of five of her elderly veteran wards and made false statements on accountings submitted to VA in order to conceal the thefts.

National Cemetery Administration

The following are examples of investigations in which National Cemetery Administration (NCA) employees have been charged with various illegal activities: (i) A foreman and a caretaker at a VA national cemetery were sentenced on charges of witness tampering. The foreman was sentenced to 6 months' home detention, 36 months' probation, and fined $2,000. The caretaker was sentenced to 6 months' home detention, 36 months' probation, and fined $1,000. The two individuals attempted to prevent witnesses from cooperating in an investigation into corruption at the VA cemetery. (ii) A NCA program assistant pleaded guilty to an indictment charging her with theft of Government property and resigned from her position. A co-conspirator in the case, an NCA program support assistant who also pleaded guilty to theft of Government property, used Government-issued credit cards to purchase merchandise that she sold for profit, gave to the program assistant, or kept for herself. Also arrested in the case was a sales representative for a company that contracted with the Government as an office supply vendor. He was charged with bribery of Government officials and conspiracy to defraud the Government. He admitted providing cash and/or merchandise to the two VA employees in return for their making purchases from his company.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for $197 Million

Audits and evaluations were conducted which focused on determining how programs can work better, while improving service to veterans. During this reporting period, 27 performance and financial audits and evaluations and 43 contract reviews identified opportunities to save or make better use of $197 million in monetary benefits. The Office of Audit returned $20 for every dollar spent on performance and financial audits. Postaward and preaward contract reviews returned $3 and $51 for every dollar spent, respectively.

Veterans Health Administration

The following are examples of major health care related audits. (i) A report on the management of employee quarters at VAMCs concluded that by phasing out VHA's quarters program, $39.8 million could be saved. (ii) An evaluation of VHA's diagnostic radiology and nuclear medicine activities concluded that radiology and nuclear medicine require standardized workload reporting and staffing guidelines, coordination in acquiring new technology, and greater oversight and direction. (iii) A report on VHA's Emergency Medical Strategic Health Care Group found improvements are needed in determining VA's role in emergency management, fiscal accountability, interagency financial support, and training and development. (iv) An audit of minor construction and nonrecurring maintenance projects identified a need for thorough reviews of project scope will enable $20 million in monetary benefits. (v) A protocol package was developed to provide Veterans Integrated Service Networks (VISNs) with an effective methodology to enhance review of Workers' Compensation Program (WCP) claims to reduce costs and identify fraud.

Veterans Benefits Administration

At the request of the Under Secretary for Benefits, and in conjunction with other OIG components, we began a comprehensive evaluation of internal controls in the Compensation and Pension (C&P) benefits program to identify vulnerabilities that could contribute to or facilitate fraud. Significant vulnerabilities were identified involving automated data processing (ADP) access and authority, claims processing procedures, and oversight. We also provided the Under Secretary suggested methods to eliminate the vulnerabilities identified.

Office of Financial Management

As part of the Consolidated Financial Statements (CFS) audit, we issued six management letters addressing financial reporting and control issues. The management letters provided Department managers additional observations and advice that will enable the Department to improve day-to-day accounting operations and controls. The management letters contained observations concerning: (i) expenditure transactions, (ii) ADP security, and (iii) VBA's benefit program.

Contract Review and Evaluation

During the period, we completed 43 contract reviews – 36 postaward and 7 preaward reviews. The postaward reviews had recoveries of $3.1 million, which have been returned to VA to fund programs. Preaward reviews of contractors' proposals resulted in recommendations that can assist contracting officers in saving $11.3 million in contract costs.

OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections' (OHI) program evaluations, hotline inspections, quality program assistance (QPA) reviews, Office of the Medical Inspector oversight, and technical 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) In keeping with our oversight responsibility of contributing to the improvement of health care delivery, we conducted an exploratory and preliminary assessment of VAMCs' missing patient policies and procedures. Patients leaving VAMCs without approval or knowledge of clinicians has been an issue that has instigated various reviews and constituent concerns. Moreover, incidents of patients missing or eloping from VAMCs can result in such consequences as serious injury or death, which undermine the public's perception of the quality of care provided to veteran patients. Our analysis showed that improvement is needed in monitoring high-risk patients, and inpatient search procedures, to reduce adverse patient incidents resulting from unauthorized absences. Also, clinical managers, who have responsibility for ensuring patient safety, need to assess and record appropriately the factors that can help define a patient's elopement risk. (ii) Our analysis of the Defense and Veterans Head Injury program operations showed that the VA Traumatic Brain Injury program is an active component. VHA clinicians are treating a broad range of head-injured patients, including evaluating and treating acute head injuries. We concluded clinicians need to strengthen coma care, refine the treatment of violent patients, and strengthen support of ventilator-dependent patients. VHA managers need to increase system-wide awareness of the program, particularly as VHA continues its transition to a primary health care model. (iii) Our nationwide assessment of the VHA's Deans Committee structure, functions, and compliance with established VHA policy guidance revealed that over time the Deans Committee structure and function has changed as a function of affiliation governance. VHA developed a revised approach to the governance of its academic affiliations with the establishment of Academic Partnership Councils. The emergence of VISNs stimulated changes in VHA's academic affiliation program and the governance of the affiliation relationship, as exemplified by the Deans Committee. VHA is shifting toward a VISN-wide role for the administration of these academic affiliations and the implementation of Affiliation Partnership Councils. As VHA continues its evolution from Deans Committees to Affiliation Partnership Councils, VHA top managers need to oversee Council functions more stringently to ensure that they adhere to law and VHA guidance. VHA also needs to revise its policy to standardize guidance for Affiliation Partnership Council operations.

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 7,289 contacts. Of this number, staff opened 396 cases, and completed 358 cases, of which 105 contained substantiated allegations. Hotline staff generated 230 letters responding to inquiries received from members of the Senate and House of Representatives. Staff recorded 35 administrative sanctions against employees and 55 corrective actions taken by management to improve VA operations and activities. The Hotline reviews found that some employees improperly used their Government credit cards, Government-leased vehicles, and Government equipment and

supplies. Reviews identified several instances of misconduct by professional staff in the care and treatment of veteran patients. A Hotline review at one VAMC uncovered plans to purchase a telephone system unnecessarily and deficiencies in other VA contracts. Reviews concerning VBA operations identified problems with a number of C&P cases that warranted corrective action by management.

The Data Analysis Section provides automated data processing technical assessments and support to all elements of the OIG and other Governmental agencies needing information from VA files. During the reporting period, the staff processed 433 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 lead to the identification of fraud, waste, and abuse. The Section responds to requests from other VA program offices and renders assistance to the investigative components of other agencies. During one joint project, OIG and VA identified over $700,000 in inappropriate benefits, and actions were taken to discontinue payments and initiate collection actions.

Followup on OIG Reports

The Operational Support Division is responsible for obtaining implementation actions on audits, inspections, and reviews with over $1 billion of actual or potential monetary benefits as of September 30, 1999. Of this amount $909 million is resolved, but not yet realized as VA has agreed to implement the recommendations, but has not yet done so. In addition, $114 million relates to unresolved reviews awaiting contract resolution by VA contracting officers. After obtaining information that showed management officials had fully implemented corrective actions, the Division took action to close 67 internal reports and 230 recommendations with a monetary benefit of $464 million.

VA AND OIG MISSION, ORGANIZATION, AND RESOURCES

The Department of Veterans Affairs (VA)

Background

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

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

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

Mission

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

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

810 Vermont Avenue, NW, Washington, DC

Organization

VA has three administrations that serve veterans:

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

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

- 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 Employment Discrimination Complaint Adjudication.

Resources

While most Americans know that VA exists, few have any idea of the size of this Department, which is the Nation's second largest in terms of staffing. For FY 1999, VA had 205,428 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 41 percent) of VA's budget in FY 1999. VHA provides care to an average of 60,000 inpatients daily. During FY 1999, slightly more than 37 million episodes of care were estimated for outpatients. There are 172 hospitals, 722 outpatient clinics, 132 nursing home units, and 40 domiciliaries.

Veterans benefits were funded at $25 billion (almost 57 percent) of VA's budget in FY 1999. The 11,324 employees of VBA provide benefits to veterans and their families. Approximately 2.6 million veterans and their beneficiaries receive compensation benefits valued at $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 467,000 home loans were guaranteed, with a value of almost $51 billion.

The National Cemetery Administration currently operates and maintains 116 cemeteries and had 1,356 employees in FY 1999. Operations of NCA and all of VA's burial benefits account for approximately $252 million of VA's $44 billion budget. Interments in VA cemeteries continue to increase each year, with almost 78,000 in FY 1999. Approximately 348,000 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 95-452) was enacted and established a statutory Inspector General (IG) in VA.

Role and Authority

The Inspector General Act of 1978 states that the IG is responsible for: (i) conducting and supervising audits and investigations, (ii) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect fraud and abuse in, the programs and operations of VA, and (iii) keeping the Secretary and the Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action.

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

Organization

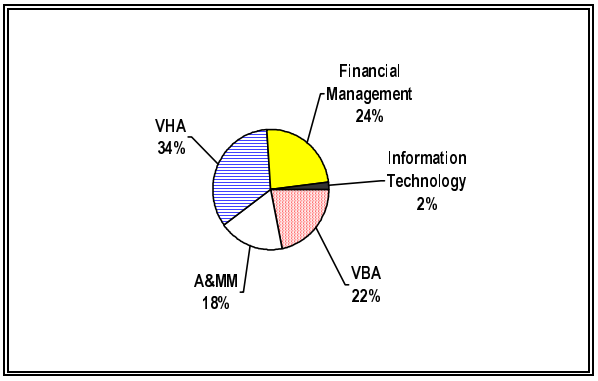
Allocated full time equivalent (FTE) for the FY 1999 staffing plan was as follows:

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

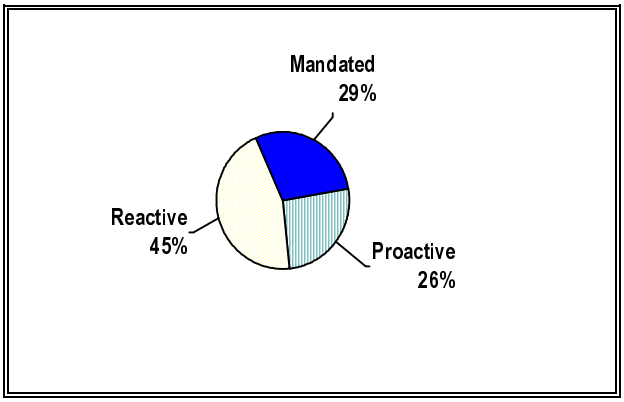
* Does not include 24 reimbursable FTE.

FY 1999 funding for OIG operations was $38.4 million, with $36 million from appropriations and $2.4 million through reimbursable agreements. Approximately 85 percent of the total funding was 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.

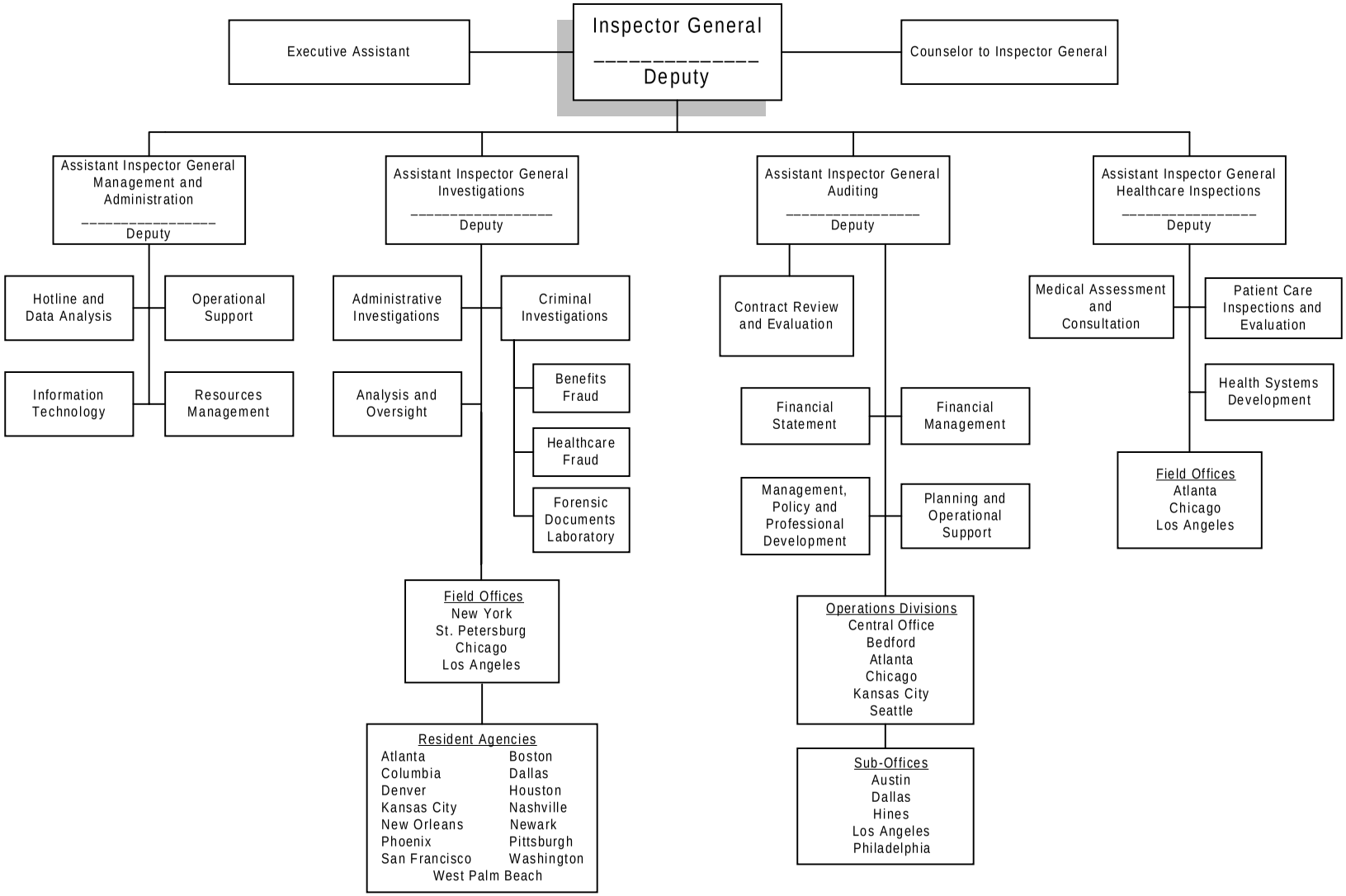
OIG Mission Statement

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



COMBINED ASSESSMENT PROGRAM

Combined Assessment Program Overview

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

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

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

Auditors from the Office of Audit conduct a limited review to ensure that management controls are in place and working effectively. Auditors assess key areas of concern which are derived from a concentrated and continuing analysis of VHA, VISN, and 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.

The following is a summary of the three CAP reviews conducted this period.

North Florida and Southern Georgia Veterans Health System Review

The OIG conducted a review of the North Florida and South Georgia Veterans Health System from February 22 through February 26, 1999. The following are highlights of our activities and areas that we identified as vulnerable and in need of greater management attention:

Quality Program Assistance Review - The results of the QPA identified several management activities that enhanced the quality of patient care. The QPA also identified areas of concern that affected the quality of patient care; these include clinical staffing issues, patients' access to care, clinic and pharmacy waiting times, food quality, employee relations issues, environmental safety, and cleanliness issues.

Management Control Issues - A number of issues were identified in which management

controls should be strengthened. Specific areas needing improvement included: purchase cards and convenience checks, clinical contracts, construction planning, warehouse and storage utilization, inventory management, telephone access security system, food and nutrition services, laboratory tests, time and attendance for part-time physicians, medical care collections fund, agent cashier, and means testing.

Office of Investigations Fraud and Integrity Awareness - Four Fraud and Integrity Awareness briefings were conducted. These briefings discussed issues concerning the recognition of fraudulent situations, referral to the Office of Investigations, and the type of information needed to make a complaint or referral. Investigators worked with auditors on agent cashier issues, advised contracting officials and risk managers on when the OIG should be contacted, and met with police officials. Additionally, a fraud referral was received from one of the System Divisions.

We made a series of observations and recommendations that we believe warrant management attention. The Director concurred with the report contents and began working towards implementing all but two of the recommendations. The Director deferred action on the recommendation to implement a telephone personal identification number system and to change line authority over staff at satellite outpatient clinics until further study is completed. We wish to point out that the Under Secretary for Health previously informed the OIG that steps were being taken to ensure telephone security systems were installed at all VHA facilities without telephone securities by September 30, 1998. The OIG may followup on telephone system actions taken at a later date. *(CAP Review, North Florida and South Georgia Veterans Health System, 9IG-CAP-502, 4/22/99)*

Southern Nevada Veterans Healthcare System Review

The OIG conducted a CAP review of the Southern Nevada Veterans Healthcare System from March 22 through 26, 1999. The following are highlights of our activities and areas that we identified as vulnerable and in need of greater management attention:

Quality Program Assistance Review - The QPA identified several issues that required management attention, including recruiting more staff to meet the expanding workload, reviewing the operation of the post-traumatic stress treatment program, improving the system for transporting patients to other VA medical centers for care, and providing employee training on violence prevention and management.

Management Control Issues - The management control review identified opportunities to improve operations by strengthening pharmacy security, properly scheduling controlled substances inspections and agent cashier audits, obtaining means test information from veterans, reducing excess inventories of supplies, revising information technology contingency plans, and pursuing employee debts.

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

The review also evaluated issues/allegations referred to the OIG by a member of Congress based on complaints made to the General Accounting Office (GAO) during a review of a prior matter. Our review of the referenced issues/allegations concluded that four areas were

substantiated and required management attention. These areas were:

Long Waits for Clinic Appointments. GAO reported allegations that patients had to wait too long for clinic appointments, particularly appointments in the specialty clinics. We confirmed this problem existed. During FY 1998, 21 of the System's specialty clinics had waiting times for new patient appointments in excess of 30 days and 7 had waiting times greater than 90 days. Management is working to address this issue by recruiting more clinical staff and by strengthening the medical school affiliation as a means of gaining physicians and residents to staff specialty clinics.

Uncorrected Construction Deficiencies in the Ambulatory Surgery Suite. GAO reported an allegation that the VA's new Ambulatory Surgery Suite had not been put into service because of uncorrected deficiencies in the suite's air conditioning system. When we began our review in March 1999, management did not have an action plan for correcting the deficiencies and opening the Suite. This occurred because System staff and VISN engineering staff were not able to reach agreement about the nature of the deficiencies and the best way to correct them. To resolve the disagreement, we suggested that VA award a contract to identify, analyze, and correct the deficiencies. System and VISN management agreed to this approach. In April 1999, management prepared the statement of work for the suggested contract. If this contract is properly managed, the Surgery Suite should be open by November 1999.

Excessive Costs for Radiology Services. GAO reported that certain employees had expressed concerns that VA might have paid too much for radiology and magnetic resonance imaging (MRI) services. This allegation was partially substantiated. The VA had negotiated reasonable contract prices for radiology/MRI procedures. However, improvement was needed in contract administration to ensure that payments were consistent with negotiated prices.

Unused Electroencephalograph (EEG) System. GAO reported that VA had purchased a $55,000 EEG system for the Neurology Clinic but had not utilized it. The system had been requested in the belief that opening the Ambulatory Care Center would lead to enough increase in EEG workload to justify an in-house capability, consisting of the EEG system and a technician to operate it. However, the anticipated workload increase did not occur, no technician was hired, and as a result, the EEG system was not utilized. At the time of our review, VA was exploring the feasibility of negotiating a sharing agreement with a community hospital to operate the EEG system at reduced rates, which could allow for the recovery of the cost.

We made recommendations that, we believe, warrant management attention. We may followup at a later date to evaluate corrective actions taken. *(CAP Review, Southern Nevada Veterans Healthcare System, 9IG-CAP-503, 6/30/99)*

Louis Stokes Cleveland VAMC Review

The OIG CAP team visited VAMC Cleveland from April 26 through April 30, 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 included:

Quality Program Assessment - The results of the QPA identified several areas of concern that affect the quality of patient care; these include waiting times for triage in walk-in clinics, patient transfers, environmental concerns in one nursing home care unit ward, quality of patient

meals, nurse-staffing levels on one nursing home care unit ward, and answering telephone calls.

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, including: billings for the medical care collections fund involving care provided by nurse practitioners, medical supplies inventory records, surgeon productivity, scheduling narcotics inspections, agent cashier audits, timeliness of reconciliations and certifications of Government purchase card transactions, information technology recovery plans, estimating workload, protocols for warehouse storage, controlling employee exposure to hazardous materials, use of reusable dialyzers, and perceptions of human resources management.

Fraud and Integrity Awareness and Hotline Allegations - Four Fraud and Integrity Awareness briefings were conducted which 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. Two additional briefings regarding fraud in the Federal Employees Compensation Act program were also conducted.

We made a series of observations and recommendations that we believe warrant management attention. The Medical Center Director provided acceptable comments to all recommendations. We may followup at a later date on planned actions until completion. *(CAP Review, Louis Stokes Cleveland VAMC, Cleveland, OH, 9IG-CAP-504, 9/24/99)*

OFFICE OF INVESTIGATIONS

Mission Statement

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

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

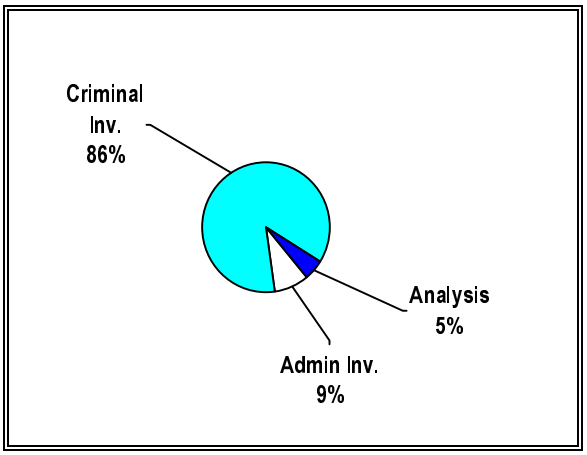
I. Criminal Investigations Division - The Division is primarily responsible for conducting investigations into allegations of criminal activities related to the programs and operations of VA. Criminal violations are referred to the Department of Justice for prosecution. The Division is also responsible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

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

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

Resources

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



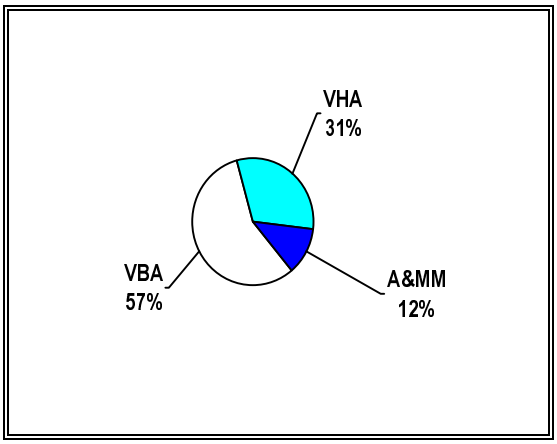
I. CRIMINAL INVESTIGATIONS DIVISION

Mission Statement

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

Resources

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



Overall Performance

Output

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

Outcome

- Indictments - 143
- Convictions - 83
- Monetary Benefits - $11.7 million
- Administrative Sanctions - 137

Cost Effectiveness

- The average cost of conducting the 138 closed investigations was $7,337. Each investigation averaged a return of $88,645, resulting in approximately $12 returned for every $1 spent.

Timeliness

- Average work days from receipt of allegation to initiation of investigation averages 32 days against a goal of 30 days.
- Average work days from initiation of investigation to referral to an assistant U.S. attorney was 215 days which did not meet our goal of 180 days.

Customer Satisfaction

- Customer satisfaction survey forms were provided to each prosecutor upon referral of an investigation for criminal prosecution. All ratings received exceeded 4.0 and averaged 4.8 out of a possible 5.0 (5.0 means highly satisfied and 1.0 means dissatisfied).

Following are summaries of some of the investigations conducted during the reporting period by VA component. We discuss VHA, VBA, and NCA. This is followed by the OIG Forensic Document Laboratory.

Veterans Health Administration

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

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 deterrent value.

Employee Integrity

Theft/Diversion of Pharmaceuticals

- A former VAMC registered nurse was sentenced to 3 months' home confinement, 5 years' probation, a $500 fine, and a $100 penalty after pleading guilty to one count of acquiring a controlled substance by fraud. He is also required to participate in a narcotics addiction

treatment program. As a result of the investigation, the nurse was discharged from his position at the VAMC. A VA OIG investigation disclosed the individual, who had been employed in the VAMC emergency room, diverted up to 2,000 milligrams per day of Demerol and Vicodin for his own use over the course of a 15-month period. Investigation found that the nurse obtained the narcotics from the emergency room narcotics cabinet and altered the Controlled Substance Administration Record, which is used to track the narcotics inventory. To avoid detection, the nurse made false entries on the record, including entering fictitious patient names, indicating that larger doses were given to patients than were actually given, listing fictitious narcotic transfers between different units of the hospital, and shortening balance-forward amounts. Additionally, the individual destroyed some records to cover up his diversion and false entries. It was found that the nurse was often under the influence of these drugs while on duty and while administering emergency health care services to veterans. An audit conducted by the VA Pharmacy Service, under the direction of the VA OIG, revealed that the nurse diverted more than 130,000 milligrams of Demerol and more than 3,300 tablets of Vicodin.

- A VAMC pharmacist was arrested and charged with stealing 400 Endocet (generic form of Percocet) tablets, and two liquid syrup medications containing the controlled substance Hydrocodone from the VAMC pharmacy. The arrest was made by special agents of the Drug Enforcement Administration and VA OIG. A VA OIG investigation disclosed the pharmacist replaced the stolen Endocet with Tylenol tablets (a non-controlled substance), and replaced the stolen Hydrocodone syrup with liquid Tylenol. In additional charges, it was alleged the pharmacist illegally obtained other controlled substances by entering two unauthorized prescriptions into the VAMC pharmacy computer in the names of two patients, one of whom was deceased.

- A former VAMC physician was sentenced to 6 months' home confinement, 36 months' probation, and was ordered to pay a $5,000 fine and restitution in the amount of $6,387. The physician previously pleaded guilty to one count of theft of Government property after a joint VA OIG and Drug Enforcement Administration investigation disclosed the physician had diverted for his own use approximately 45,620 doses of codeine over a 3½-year period. He accomplished this diversion via two separate schemes. Initially, he recruited several veteran patients at the VAMC and told them that he was helping an uninsured patient that needed codeine. He would give the veterans prescriptions for codeine, which they would have filled at the VAMC pharmacy and then turn over to the physician. Eventually, the physician began writing codeine prescriptions for some of his patients, which he would drop off at the VAMC pharmacy and then pick up himself. He would indicate to the pharmacy personnel that he would see the patient later that day and would give the medications to the patient at that time. The patients were not aware that the physician was writing these prescriptions and never received the drugs.

- A VAMC nurse was arrested by VA OIG and Food and Drug Administration special agents and subsequently indicted on charges of tampering with consumer products. Investigation disclosed the individual used syringes to withdraw Demerol from vials for his personal use, refilled the vials with saline solution and returned them for distribution to veteran patients. The individual admitted his actions in a signed sworn statement given during the course of the investigation. Further action in the case is pending.

Possession/Sale of Illegal Drugs

- A joint investigation by the VA OIG, VA police, and local law enforcement officials resulted in two VA employees pleading guilty to possession of controlled substances on VA property. Both employees became subjects of the investigation after a coordinated gate search using drug-sniffing dogs, was conducted as employees left the property after work. The search was conducted based on allegations received that drug trafficking was taking place on the VAMC grounds. Additional gate searches were subsequently conducted, resulting in more arrests. The investigation continues.

- Twenty-four individuals were arrested by VA OIG special agents, in an effort to break up a drug-theft ring. A joint investigation by the VA OIG, Food and Drug Administration, and local police disclosed that a conspiracy was taking place among a group of individuals to purchase controlled pharmaceuticals from Medicaid recipients. The conspiracy targeted drugs which could be obtained at no cost to the recipients and which were easily obtained from Government sources such as VA pharmacies. Investigation showed many of the drugs that have been sold in the conspiracy were represented to the conspirators as having been stolen or otherwise diverted from VA pharmacies.

Theft and Embezzlement

- A former VAMC chief of prosthetics and sensory aids was indicted by a Federal grand jury, charged with one count of theft of Government property. A VA OIG investigation disclosed the individual ordered personal computers and related software items using fraudulent VA purchase orders, and shipped them to his residence and other locations for his own personal use. Loss to VA exceeds $20,000.

- A former VA medical and regional office center (VAM&ROC) police officer pleaded guilty pursuant to an arrest and indictment on charges of theft. A joint VA OIG and VA police investigation disclosed that, after an employee at the VAM&ROC reported her laptop computer missing, the officer took a report from the employee and reported that the laptop computer had likely been stolen and would not be recovered. Subsequent investigation, however, determined the officer had stolen the computer and pawned it for cash. During questioning subsequent to his arrest, he admitted stealing at least four computers. After this admission, VA immediately issued subject a notice of termination. Sentencing is pending.

- A former VAMC laboratory technician was arrested following an indictment by a grand jury on charges of embezzlement of funds. While employed at the VAMC, the laboratory technician was detailed to the American Federation of Government Employee local office as union president. A joint investigation by members of VA OIG, U.S. Department of Labor (DOL), Office of Labor Management Standards, and the Federal Bureau of Investigation (FBI) disclosed that, while acting as president, the former employee embezzled union funds in excess of $41,000 by writing checks from the union's account payable to herself, family members, and for personal expenses. She also withdrew funds from the union's account at several automatic teller machines and made purchases for her personal use using the union's bank debit card. Judicial action is pending.

- An individual who was the former treasurer of a labor union representing workers at a VAMC was sentenced to 4 months' home confinement with electronic monitoring, 170 hours of community service, and ordered to make restitution of $19,511 to the union. The individual previously had pleaded guilty to one count each of embezzlement and false

statements. The guilty plea and subsequent sentencing were the result of a joint VA OIG and DOL investigation.

- A former VA outpatient clinic agent cashier pleaded guilty to one count of theft of Government funds. The individual admitted that, over a 4-year period, she embezzled more than $10,000 in medical and prescription drug co-payments made by patients, converting the funds for her own use. As a result of the investigation, the individual resigned from her position with VA. Sentencing is pending.

- A former VAMC carpenter signed a pretrial diversion agreement admitting that, over a 2-year period, he stole 16 air conditioners from the VAMC for his personal use and monetary gain. He was ordered to pay $5,500 in restitution to the VAMC as part of the agreement. During the course of the investigation, VA OIG special agents executed a search warrant, at which time they confiscated five of the air conditioners from an auto repair shop, where the individual had stored them in an attempt to avoid detection. The remaining air conditioners were allegedly sold or given away by the individual.

- A former VAMC administrative officer in the Research Service pleaded guilty to a one-count criminal information charging him with theft of Government funds. A VA OIG investigation disclosed the individual filed false travel vouchers in connection with a permanent change of station move. In his plea, the individual admitted he had claimed $9,200 in false moving expenses that were subsequently paid by VA. The individual had resigned his VA position at the onset of the investigation. Sentencing is pending.

- A former VAMC licensed practical nurse was sentenced to 5 months' imprisonment, 5 years' supervised release which includes 5 months' electronic monitoring, and restitution of $33,350. The individual previously had pleaded guilty to two counts of bank fraud after a VA OIG investigation disclosed he had stolen personal checkbooks from two veteran patients at the VAMC and then wrote checks to himself by forging the veterans' signatures. Several of these checks were written after the veterans had died. Investigation further revealed he also forged the endorsement on two U.S. Treasury checks made payable to one of the veterans.

- A VAMC nursing assistant pleaded guilty to computer fraud and grand theft after being arrested by VA OIG special agents. The plea was the result of a joint VA OIG and state Department of Motor Vehicles investigation, which disclosed the nursing assistant obtained a patient's personal information from the hospital computer system. He then used this information to apply for and obtain a temporary state driver's license. The nursing assistant used the temporary driver's license and the patient's personal information to obtain a credit card, telephone account, and automobile financing under the patient's name. The patient did not know the nursing assistant and did not give permission to use his identity.

- An individual formerly employed by VA as a computer specialist was sentenced to 2 years' probation, $1,000 restitution, and $1,500 in fines after pleading guilty to a one-count criminal information charging him with theft of Government property. A VA OIG investigation disclosed the individual, who came under investigation in response to allegations that he was selling VA-owned computers and computer parts, sold a computer that contained VA-purchased parts to an undercover agent. He admitted during the investigation that, over the past 7 to 8 years, he had stolen and sold VA computers and parts valued at over $11,000. He admitted to realizing at least $6,500 in cash profits from the sale of either stolen VA computers, or computer systems that he constructed using stolen VA parts.

Acceptance of Bribes, Gratuities, Conflicts of Interest

- A former VA outpatient clinic medical travel clerk pleaded guilty to charges of accepting gratuities while functioning as a public official. She was sentenced to 2 years' probation and ordered to pay a $1,500 fine. A VA OIG investigation revealed the individual accepted monetary gratuities from the owners of a medical transportation company in exchange for giving their company extra business. As travel clerk, her duties included arranging transportation for veterans and working with contractors enrolled in providing transportation service to ambulatory and wheelchair-bound veterans. She was responsible for selecting the contractor to transport veterans to and from a designated VA medical facility.

- A former VAMC labor gang foreman was sentenced to 3 years' probation and ordered to pay a $3,000 fine after pleading guilty to one count of conspiracy to accept an unlawful gratuity. The sentencing was the result of a joint VA OIG and Defense Criminal Investigative Service (DCIS) investigation concerning VA employees accepting bribes and gratuities in return for having recommended approval of numerous purchases orders. The foreman admitted he recommended approval of eight orders to purchase $22,000 of hand and machine tools and landscaping supplies and services from VA contractors who supplied the products. The contractors involved previously pleaded guilty to conspiracy charges.

Workers' Compensation Benefits Fraud

- A former VAMC laborer was sentenced to 5 years' probation and ordered to pay restitution of $8,400. A joint VA OIG and DOL investigation disclosed the individual injured his back while on the job in 1994 and was terminated from employment in 1995 when it was determined that his injuries were not going to allow him to work again. At the time of his termination, he started collecting workers' compensation benefits. He failed to report, however, that he was earning income of $15,000 a year as a dog-handler while collecting the benefits. As a result, he received over $55,000 in benefits to which he was not entitled.

- A former VA veterans outreach specialist was sentenced to 12 months' and 1 day's incarceration, 3 years' supervised release, and ordered to pay restitution of $324,700. The sentencing was the result of a previous guilty plea to a nine-count indictment charging him with workers' compensation fraud, making false statements, and mail fraud. A VA OIG investigation disclosed that, for almost 13 years, the individual illegally collected over $320,000 in workers' compensation benefits, claiming 100 percent disability from an on-the job-injury. During that time, he submitted yearly forms to the DOL's Office of Workers' Compensation Programs certifying he was unable to work due to the disability. The investigation revealed that, while the individual was collecting benefits for his inability to work, he was, in fact, working a series of jobs including counselor at a military academy, school psychologist at an elementary school, adjunct professor at a university, private therapist, owner and operator of two bus companies, and co-owner and director of both a preschool and an infant evaluation center.

Credit Card Fraud

- A former VAMC program support clerk pleaded guilty to defrauding VA and a state Department of Public Aid. In a joint VA OIG and Postal Inspection Service investigation, it was disclosed the individual used a VA-issued credit card for personal use, resulting in a loss to VA of more than $3,700. The investigation further disclosed that the individual applied for state public aid, failing to disclose her employment with VA on the application, causing

a loss of more than $39,000 in fraudulent benefits payments. Sentencing in the case is pending.

- A former VAMC library technician was indicted in a state court and charged with two counts of felony theft. A VA OIG investigation revealed the individual used her Government IMPAC credit card to purchase items for her personal use. The investigation further determined that the library technician, who had been elected treasurer of the VA Employees Association, misappropriated approximately $10,000 from the association's account into her personal bank accounts.

- A former VAMC program support assistant pleaded guilty to one count of theft of Government property after he was arrested on charges of credit card fraud by VA OIG special agents. A joint VA OIG, U.S. Secret Service (USSS), and U.S. Postal Inspection Service investigation disclosed the individual received a Government credit card in the mail shortly after he had been terminated from his VA position. Despite the fact that the card was marked "For Official Government Travel Only" and he had been terminated from employment, he activated the card and used it to charge over $6,000 worth of personal items. Sentencing is pending.

- An individual pleaded guilty to one count of credit card fraud and one count of conspiracy to commit credit card fraud. The plea resulted from a joint VA OIG and USSS investigation, which disclosed the individual had fraudulently obtained a Government credit card issued to a former VA employee. The individual thereafter used the credit card to make unauthorized withdrawals in excess of $95,000 in cash from multiple automated teller machines.

Patient Abuse/Death

VA nurse
charged in neglect
of patient

[photo not available electronically]

- A former VAMC dialysis nurse was arrested on charges of knowingly, and willfully or by culpable negligence, neglecting a disabled adult, and by doing so causing him great bodily harm. The arrest was the result of a joint VA OIG and

local police investigation which disclosed the individual improperly connected a kidney dialysis machine to a disabled veteran in her care, and then left him unattended while she attended to personal business. The improper connection caused the veteran's blood to drain into a plastic container and overflow rather than return to his system. After discovering that more than two liters of the veteran's blood had drained from his body, the individual, assisted by co-workers, took actions, which appeared to be an attempt to cover up what happened. These actions included cleaning up the blood with rags and surreptitiously disposing of them, and pouring the blood into a washroom sink before calling for medical assistance. The investigation disclosed 45 minutes elapsed from the time the blood loss was discovered by the nurse until medical assistance was summoned. When the medical assistance team arrived, members were not informed of the massive loss of blood, later determined to be the cause of the veteran's death.

- A Federal grand jury returned a superseding indictment charging a former VAMC nurse with first degree murder of a VAMC patient and assault with intent to commit murder of another patient. These charges are in addition to charges filed against the former nurse in an earlier indictment returned in November 1998. With the advent of these newest charges, the U.S. Attorney filed a notice to seek the death penalty in this case. The superseding indictment charges, as did the original indictment, that the former nurse used a heart stimulant to assault and murder three VAMC patients, and that she assaulted two additional patients with intent to commit murder, also by injecting them with the stimulant. The superseding indictment adds the additional charges of murder, and attempted murder and assault with intent to commit murder. All of the victims were patients at the VAMC where the nurse worked.

Ex-Nurse Could Face Death

[photo not available electronically]

- A former VAMC nurse was sentenced to 1 year's probation after having been convicted at trial on one count of making false statements. The conviction was the result of an investigation conducted by VA OIG following receipt of a complaint from a VAMC patient. The investigation determined the former employee, a registered nurse assigned to the long-term psychiatry unit, made false statements to VA OIG special agents denying that she routinely slept on duty during her shifts. For the majority of the nights, she was the only registered nurse assigned to the unit and the only staff member allowed to dispense medications to patients.

- A VAMC police officer was convicted in municipal court on charges of tampering with physical evidence and was sentenced to 90 days' imprisonment. A joint investigation by VA OIG, VA police, and the FBI disclosed a physical altercation took place between a patient and a VA employee during which the patient sustained minor injuries. The VA employee, who was not injured, denied striking the patient and advised that the patient had struck him instead. The VA police officer, who responded to the incident, issued a citation for disorderly conduct to the patient. When interviewed during the course of the investigation, the officer admitted throwing away the statement he received from another patient that corroborated the victim patient's story of the assault by the VA employee.

- A former VHA licensed practical nurse was sentenced to 3 years' supervised release and 40 hours of community service. The individual previously had pleaded guilty to one count of assault on a patient after a VA OIG investigation disclosed she struck the patient, a 77-year old veteran who was a resident of a VA extended care unit. Investigation further showed the victim suffered from dementia and was unable to make a complaint or defend himself against the actions of the nurse.

Other Employee Misconduct

- A VAMC occupational therapy assistant, and his daughter, both pleaded guilty to one count of conspiracy to commit mail fraud and wire fraud. The guilty pleas followed indictments, which charged the individuals with accepting money for items, and not providing the items to buyers. Investigation disclosed the subjects sent and received electronic messages, using VA's Internet services, to advertise and sell products. They obtained more than $40,000 by U.S. mail and wire transfers while operating this fraudulent scheme.

- As the result of a joint investigation between VA OIG special agents and VA police, a violation notice for commercial solicitation and vending was issued to a physician's assistant working in a VA outpatient clinic. Investigation disclosed the physician's assistant was soliciting patients and staff to purchase a fruit juice which he purported to provide medicinal benefits. He told patients that the juice was an anti-inflammatory, and that he was conducting VA-sanctioned research. The issuance of the violation notice mandates an appearance before a Federal magistrate judge.

- An individual employed in a VAMC compensated work therapy division pleaded guilty to charges of possession and reproduction of child pornography on Government property. A VA OIG investigation disclosed the individual accessed the shared computers in the VAMC's library to download and print more than 11 pages of pornographic material portraying children. Sentencing is pending.

- A former VA information security officer was sentenced to 27 months' incarceration, 36 months' probation, and ordered to pay a fine of $2,000 for possession of child pornography on Government property. A VA OIG investigation disclosed the individual stored numerous

sexually explicit images of children, some under the age of 12, on his VA computer.

Control of Drugs

A veteran was sentenced to 36 months' probation and ordered to pay $500 in fines after he was indicted and pleaded guilty to charges of attempting to obtain a controlled substance by fraud. A joint VA OIG and VA police investigation disclosed the individual presented an altered prescription to a VAMC pharmacy in an attempt to obtain Percocet. Investigation further disclosed the individual had presented altered prescriptions on two prior occasions, successfully obtaining quantities of Percocet to which he was not entitled.

Theft of Other Property

A VAMC outpatient, who previously had been arrested on charges of stealing checks from a fellow patient, was sentenced 6 months' incarceration, 3 years' probation, and ordered to pay $3,000 in restitution. A VA OIG investigation disclosed the individual stole blank checks from a veteran residing in a VA nursing home, forged the veteran's signature and cashed the checks, resulting in a theft of approximately $3,000.

Threats to VA Employees

- An individual recently terminated from her employment in the VAMC radiology unit was arrested for making death threats to various VA employees with whom she had worked. A joint VA OIG and FBI investigation disclosed the individual left threatening voice mail messages indicating she wanted to kill her supervisor and other VA employees.

- A criminal complaint and arrest warrants were issued charging two individuals with collection of credit by extortion. A joint VA OIG and VA police investigation disclosed the two individuals entered a VAMC and threatened to harm a VA employee if he did not pay them money he had borrowed, at the rate of 20 percent interest every 2 weeks. The two individuals were subsequently arrested by VA OIG special agents. One of the individuals was released on a $25,000 bond, while the second, who was serving 5 years' probation for a 1998 felony robbery conviction, was held pending the receipt of additional bond requirements.

- An individual was arrested by VA OIG special agents pursuant to a warrant charging him with assaulting and threatening a VAMC doctor. After being arrested, the individual was arraigned and ordered to stay away from the VAMC, and to have no contact with the doctor. The individual was further ordered to appear before the court in November 1999, or face a fine or imprisonment of up to $1,000 or 180 days, or both.

Armed Robbery

An individual formerly employed by a credit union located at a VAMC was found guilty in a jury trial of one count of bank robbery. A joint investigation by VA OIG, FBI, and local police disclosed that the former employee assisted another individual, not employed by VA, in planning the robbery of the credit union for over $147,000. The associate, who previously pleaded guilty has already been sentenced. Sentencing for the former employee is pending.

Construction Related Fraud

A construction company that contracted to perform VAMC renovations, and its former comptroller and project manager, were all sentenced in U.S. District Court after pleading guilty to charges of making false statements. The construction company was sentenced to 3 years' probation and a $25,000 fine. The

comptroller was sentenced to 2 months in a halfway house, 6 months' home detention, and 3 years' probation. The project manager was sentenced to 3 years' probation, 6 months' home confinement with electronic monitoring, and a $2,000 fine. The construction company had previously pleaded guilty to two counts of making false statements. The comptroller had pleaded guilty to two counts of conspiracy to make false statements and the project manager had pleaded guilty to one count of making fraudulent demands and possession of false papers with the intent to defraud. The guilty pleas and sentencings were the result of a joint investigation conducted by the VA OIG, DCIS, DOL, and Army Criminal Investigations Division. The construction company and its two employees admitted submitting false certified payrolls to DOL on VA and Army contracts.

Procurement Fraud

- An individual, who served as business manager for a medical testing company, pleaded guilty to a one-count criminal information charging her with conspiracy to defraud the United States by billing for unnecessary laboratory tests. Two additional individuals, the president and the former product manager for the company, were both indicted on 16 counts of mail fraud and one count of conspiracy to defraud the United States. A joint VA OIG, Department of Health and Human Services (HHS) OIG, and DCIS investigation disclosed the individuals involved in the conspiracy encouraged clinics to order or arrange for laboratory blood testing services for dialysis patients through the company. The services were paid primarily by Medicare; however, VA paid the company more than $1 million for VAMC laboratory services. Sentencing is pending.

- A former Vocational and Rehabilitation Counseling Service psychologist pleaded guilty to a one-count criminal information charging him with conspiracy to file false claims. The individual's guilty plea was in response to evidence developed during a joint VA OIG and FBI investigation, which disclosed the individual approved invoices totaling approximately $68,000 for computer purchases that a co-conspirator had submitted to VA. The computers, intended for the use and training of disabled veterans, were never delivered. For his part in the scheme, the individual received more than $50,000. The co-conspirator, owner of a private company which supplied the computers, previously was convicted and pleaded guilty to similar charges. A sentencing date for the former VA employee is pending.

- A VAMC director of respiratory care pleaded guilty to soliciting and receiving a laptop computer for her personal use from a VA contractor in exchange for purchasing medical supplies and laboratory equipment from the contractor. Sentencing is pending.

- A contractor that supplied surgical instruments to VA agreed to pay a settlement of $1,334,000 to the Government after being charged with violation of the False Claims Act. The settlement is the result of a VA OIG investigation which disclosed the contractor, who was awarded a Federal Supply Schedule contract, violated the Trade Agreements Act. Specifically, the contractor certified during the contract negotiation phase that they would only supply VA surgical instruments manufactured in Germany. Instead, the company shipped imported surgical instruments to VA and other Government agencies that were manufactured in Malaysia and Poland. Both are considered non-designated countries and prohibited from participating in Federal procurements.

- An individual who had a contract to distribute latex examination gloves to VA was charged with introduction or delivery of misbranded devices into interstate commerce, fraud, and false statements. A joint investigation

by VA OIG, Food and Drug Administration, and FBI revealed the distributor sold gloves, which were not medical grade, to a Federal Supply Schedule contractor who, in turn, supplied the gloves to numerous VAMCs. The total amount of the sales was more than $329,000. Judicial action is pending.

Contract Fraud

- An individual who contracted with VA to supply tools and supplies was sentenced to 73 months in prison and restitution of $10,000 for conspiring to defraud VA and DoD on Government contracts valued at more than $400,000. The individual was first charged in a 19-count criminal indictment charging him with conspiracy to bribe VA and DoD officials, submitting false statements and false claims, counterfeiting DoD's official seal, mail fraud, and attempted bribery. He pleaded guilty at that time to separate charges of using a fake passport to flee the country with his wife and filing a U.S. Customs form in a false name. The individual admitted that, with the assistance of his wife, he paid bribes to VAMC and DoD officials in order to influence the awarding of Government contracts to his companies. The bribes included thousands of dollars in cash and items such as a motorcycle, air compressor, chain saw, cigars, and bottles of liquor. As a result of the bribes, his companies were awarded approximately 190 VA contracts valued at more than $132,000 to supply hand tools, machine tools, and landscaping supplies and services. Some of the Government officials to whom he paid bribes have pleaded guilty to accepting the bribes.

- Three individuals each pleaded guilty to one count of conspiracy to submit false statements. The plumbing companies, which employed the three individuals and had contracted to perform plumbing work for VA, separately pleaded guilty to one count of false statements. The guilty pleas were the result of an indictment that charged the individuals and the companies with having submitted false payroll records to the Government. A VA OIG investigation disclosed that, between 1995 and 1998, payrolls were submitted that overstated the actual wages paid to employees. The companies underpaid employees in wages and benefits resulting in approximately $700,000 in additional Government payments to which the companies were not entitled.

Fee Basis Fraud

- An individual entered into a deferred prosecution agreement with the U.S. Attorney's Office after a criminal complaint was filed against her, charging her with one count of false claims. During the course of a joint VA OIG, USSS, and Postal Inspection Service investigation, the individual admitted she submitted false billings to VA for home health care expenses incurred allegedly caring for her father and seeking reimbursement of approximately $40,000. During the time she was allegedly caring for her father in her home, he was confined to a hospital, which was rendering care.

- A nurse, who treated veterans under a fee basis arrangement with VA, was indicted by a Federal grand jury and charged with four counts of wire fraud and two counts of submitting false claims. The indictment was the result of a VA OIG investigation which determined the nurse submitted false invoices for nursing visits to patients that she did not perform. Investigation disclosed the nurse submitted more than $43,900 in false billings. A trial date is pending.

Travel Benefits Fraud

A veteran was arrested by VA OIG special agents on charges of theft of VA travel benefits. A joint VA OIG and VA police investigation disclosed the veteran, a VAMC outpatient, provided a false address on his records, claiming

he lived outside a 20-mile radius of the VAMC, which enabled him to file claims for travel reimbursement. Investigation found he actually lived within the 20-mile radius. Over a 2-year period, the individual received approximately $8,000 in travel benefit reimbursement payments to which he was not entitled.

Veterans Benefits Administration

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

Loan Guaranty Program Fraud

Loan Origination Fraud

- A former VARO loan guaranty representative was indicted on one count of embezzlement. A VA OIG investigation disclosed the individual embezzled funds from veterans seeking his assistance on problems associated with their VA-guaranteed home loans. When the veterans sent him money to be applied to their loans, he wrongfully converted more than $4,000 for his own use. Judicial actions are pending.

- An individual pleaded guilty to a charge of submitting false statements to a lending institution in order to obtain a VA-guaranteed loan. A Federal grand jury had previously returned a seven-count indictment against the individual. The fraudulent activities surfaced after the individual defaulted on his mortgage loan within 12 months of origination, triggering an audit of his loan processing documents, which disclosed the presence of conflicting information. A VA OIG investigation confirmed the application contained inflated income information and false supporting documentation, which served as the basis for his loan approval. The subsequent default and foreclosure resulted in a $33,100 loss to VA.

- A veteran and his spouse were sentenced after pleading guilty to charges of conspiracy to obtain a VA-guaranteed home loan, making false statements in order to obtain a VA-guaranteed home loan, making false statements on a Federal credit union loan application, and using a false Social Security number. The veteran, who pleaded guilty to two counts of the original 29-count indictment, was sentenced to two concurrent 11-month prison terms, two concurrent periods of probation, 3 and 5 years respectively, and was ordered to pay $10,000 in restitution. The veteran's spouse, who pleaded guilty to six counts of the original 29 count indictment, was sentenced to 6 concurrent periods of 3 years' supervised probation and was ordered to pay $10,000 restitution. A joint VA OIG and USSS investigation disclosed the couple provided false income information in order to obtain the VA-guaranteed mortgage loan, on which they subsequently defaulted. The couple also used false information on other credit applications. Loss to VA is approximately $132,800.

Equity Skimming

An individual was sentenced to 78 months' imprisonment, a fine of $15,000, and court ordered restitution of $571,000 after conviction at a jury trial on charges of equity skimming, mail fraud, bankruptcy fraud, and money laundering. A VA OIG investigation disclosed the individual fraudulently assumed 61 properties with mortgages guaranteed by VA or insured by HUD, rented the homes, and kept the rent monies for himself without making the required mortgage payments. His actions caused all of the loans to go into default and eventual foreclosure. In addition, he delayed foreclosure proceedings by filing multiple bankruptcies under fictitious names. He deposited and withdrew large sums of cash, so he could launder the illegal proceeds of the scheme.

Property Management Fraud

An individual pleaded guilty to one count each of making a false statement to VA and to HUD. The individual previously was indicted on 25 counts of making false statements following a joint VA OIG and HUD investigation which determined that he misrepresented himself as a licensed real estate broker in order to participate in brokering the sale of repossessed VA and HUD homes. The individual, whose real estate license had expired, altered the expiration date on his license in order to make himself appear eligible to participate in real estate transactions. Through his actions, he received commissions to which he was not entitled on sales of homes. Sentencing is pending.

Unacceptable Bidding Practices

- Two VA employees, one a veterans service center manager and the other a VARO director, were issued a reprimand and letter of counseling, respectively, for their roles in the noncompetitive issuance of a contract to a firm to provide transcription services for the VARO. The manager was reprimanded for having participated substantially in the award of the contract, a potential conflict of interest because the firm employed two of his children. The director received a letter of counseling because he authorized improper procurement procedures to obtain the contract.

- A VA OIG investigation disclosed evidence that two employees in a VARO loan guaranty division engaged in favoritism and unacceptable bidding practices. The first employee was terminated from employment after the investigation showed she acted as a property management specialist for a number of VA portfolio properties on which successful bids had been made by her outside employer, a financial services company. Most of the bids submitted by the company were slightly above the minimum acceptable offer amounts, a confidential value set by VA, which led investigators to believe she was engaging in unacceptable practices. In addition, she personally met with a bidder who also happened to be her home insurance broker, to obtain signatures on bid submission documents, creating the appearance of favoritism. The second VA employee, who also was employed by the same financial services company, was demoted two grades based on the findings of the investigation, which showed the outside employment created an appearance of impropriety and favoritism.

Beneficiary Fraud

Employee Misconduct

- A former VARO supervisor was sentenced to 33 months in prison and ordered to pay $615,472 in restitution to VA. She also agreed to forfeit more than $300,000 in personal and real property, including two vehicles. The sentencing follows a guilty plea to one count of engaging in an unlawful monetary transaction

(money laundering) involving the proceeds of a mail fraud and larceny scheme. A VARO senior claims examiner also was arrested in the case, charged with conspiracy to steal public money, theft of public money, obstruction of agency proceedings, and destruction of public records, after it was disclosed the claims examiner conspired with the former supervisor to create a fraudulent VA disability award on the supervisor's behalf. A VA OIG investigation disclosed the former supervisor created computerized records which fraudulently reflected that her fiancé was entitled to receive large amounts of VA disability payments to which he was not entitled. Investigation further revealed the claims examiner destroyed Government records relating to the crime and advised the former supervisor to provide false information to investigators. The former supervisor caused the benefit monies to be deposited into an account bearing both their names, wrongfully obtaining more than $615,000 in VA benefits.

- A former VARO ratings specialist was sentenced to 33 months' imprisonment, 3 years' supervised release, and ordered to pay restitution of $588,872. He previously had pleaded guilty to stealing VA compensation benefits after a VA OIG investigation revealed he had created a record for a fictitious veteran and awarded this fictitious veteran benefits for service-connected disabilities. For more than 12 years, he continued the fraud, causing VA to deposit more than $588,000 in monthly benefit checks into a savings account he opened in the name of the fictitious veteran. Each month the individual withdrew funds from the account. In 1998, he was arrested by local police on an unrelated charge. At the time of his arrest, he was in possession of multiple identification documents including documents in the name of the fictitious veteran. While under surveillance, he made a withdrawal from the account and was immediately arrested by VA OIG special agents as he exited the bank. At the time of his arrest, he was in possession of $10,000 cash.

Dependency & Indemnity Compensation (DIC) Benefits Fraud

- The widower of a VA beneficiary was indicted and charged with theft of Government funds. This individual's wife was a VA beneficiary, the surviving spouse of a deceased veteran, whose payments should have ceased upon her remarriage. A joint VA OIG and USSS investigation disclosed, however, that the wife failed to notify VA that she had remarried in 1983, and then the spouse, in turn, failed to notify VA when his wife, the VA beneficiary, died in 1988. Between 1988 and 1997, VA benefit payments totaling over $80,044 were deposited into his checking account, during which time he also re-married. In 1997, the individual shot his present wife, who had threatened to disclose his illegal receipt of VA monies. The information regarding the fraud surfaced during the investigation of the shooting by the local sheriff's office. The individual was convicted of malicious wounding and is presently incarcerated. Judicial action on the fraud charges is pending.

- An individual was indicted and charged with arson, insurance fraud, and defrauding VA following a joint investigation by the VA OIG, a state fire marshal's office, and a state Insurance & Safety Fire Commission. The individual, the widow of a deceased veteran, was under investigation for a suspicious fire that destroyed her home and belongings. In addition to arson and false insurance claim charges, the indictment charges that the widow misrepresented her marital status on a VA application for VA DIC benefits and received benefits to which she was not entitled. The loss to VA is estimated at over $32,000.

- An individual was indicted by a Federal grand jury on 10 counts of mail fraud and 6

counts of forgery following a VA OIG investigation which disclosed she wrongfully diverted VA DIC benefits payments. Investigation showed she failed to inform VA about the death of her mother, a VA beneficiary, and continued to collect the benefits checks as they were sent by VA, converting more than $7,800 in VA benefits to her own use.

- An individual was arrested by special agents of the VA OIG, U.S. Marshals Service, and military police, as the result of a criminal indictment on charges of making false claims against VA, and a subsequent charge of failure to appear in court to answer the false claims charges. Investigation disclosed that the individual filed a claim to receive benefits as the widow of a veteran, failing to report her remarriage, which would have caused the benefits to cease. She forged the signature of a veteran to whom she claimed to have been married on VA documents designating her as a beneficiary. As a result, the individual received over $33,000 in DIC benefits to which she was not entitled.

- A criminal information was filed against an individual who wrongfully diverted his deceased mother's DIC benefits and used them for personal expenses. A VA OIG investigation disclosed that, from the time of the mother's death in 1995 until 1997, the individual failed to report the death and continued to allow benefits payments to be electronically deposited by VA into a joint bank account that he shared with his mother. Over a 2½-year period, the individual received more than $33,600 to which he was not entitled.

- An individual was indicted on one count of theft of Government funds after a VA OIG investigation disclosed that she concealed her mother's death in 1993 in order to continue receiving VA benefits. For almost 6 years, the individual continued to negotiate her mother's VA DIC benefits checks, resulting in a loss to the Government of more than $62,000.

- An individual was indicted on one count of forgery after a joint VA OIG and FBI investigation disclosed that he concealed his mother's death in order to continue receiving VA benefits in her name. After the mother's death in 1986, the individual continued for almost 9 years to negotiate her VA DIC benefits, resulting in a loss to the Government of more than $78,000.

- An individual pleaded guilty to a criminal information charging him with theft of Government funds. A VA OIG investigation disclosed the individual, who was a friend of the widow of a veteran, converted VA DIC benefits intended for the widow, after failing to notify VA of the widow's death in 1991. Investigation disclosed that he forged the widow's signature on documents which he submitted to VA in order to continue the issuance of electronically deposited funds. He used automated teller machines and forged checks to convert more than $32,000 to his own use. Sentencing is pending.

- An individual was indicted by a Federal grand jury on one count of theft. The indictment was the result of a VA OIG investigation which determined the individual failed to report the death of her mother to VA and the Social Security Administration (SSA), and continued for more than 30 years to divert benefits intended for her mother from both agencies. As a result of her actions, the individual received more than $85,000 in SSA retirement/survivors insurance benefits, and more than $26,000 in VA benefits to which she was not entitled.

- An individual was sentenced to 4 months' incarceration, 4 months' home detention, 1 year's supervised release, and ordered to pay restitution of $56,890 to VA after a VA OIG investigation disclosed the individual

fraudulently received and negotiated benefits payments intended for her deceased mother. She failed to notify VA of her mother's death and continued for more than 10 years to divert the benefits payments. Loss to VA was in excess of $76,000.

- An individual was indicted on one count of theft of Government funds after a joint VA OIG and USSS investigation disclosed that she failed to report her mother's death to authorities and, instead, intercepted and cashed VA benefits checks intended for her mother. Loss to the Government was more than $5,700.

- A husband and wife were each sentenced to 5 years' probation, ordered to pay a fine of $500 and $17,250 in restitution. The couple previously pleaded guilty to uttering a forged writing after a VA OIG investigation revealed the couple fraudulently received and negotiated U.S. Treasury checks intended for the wife's deceased mother.

- An individual pleaded guilty to one count of theft of Government funds and one count of misprision of a felony after previously being indicted by a Federal grand jury on the theft count. She was recently charged with the misprision count in a superceding bill of information. A VA OIG investigation revealed the individual failed to notify VA of her mother's death, continuing to access VA DIC benefits that were electronically deposited into the deceased mother's bank account. Loss to the Government is approximately $94,600. She was charged with misprision of a felony after investigation disclosed her connection with a scheme to commit Government program fraud.

- An individual who had custodial responsibility for a VA beneficiary's affairs prior to the beneficiary's death in 1992 was sentenced to 4 months' home detention, 1 year supervised release, and was ordered to pay $58,272 restitution to VA. The individual previously pleaded guilty to a one-count criminal information charging her with fraudulently accepting VA DIC compensation benefits on behalf of the deceased beneficiary. The custodian's husband previously pleaded guilty and was convicted for his role in aiding or assisting his spouse in concealing receipt of the benefits monies by excluding the income on a joint Federal tax return. He was sentenced to 5 months' incarceration, 5 months' home detention, 1 year's supervised release, and was ordered to pay $58,272 in restitution to VA after pleading guilty. The guilty pleas and resulting sentencings were the result of a joint VA OIG and Internal Revenue Service (IRS) investigation which disclosed that $58,272 in disbursements were illegally diverted by the custodian, following the death of the beneficiary, and were not accounted for as income on the custodian's Federal tax return.

Pension Benefits Fraud

Veterans service officer faces federal charges

[photo not available electronically]

- An individual who served as a county veterans service officer and two individuals who worked as home health care providers were indicted by a grand jury on nine counts each of defrauding VA. Each individual was charged with one count of conspiracy to defraud the United States and commit wire fraud, and each was charged with eight separate counts of wire fraud. The indictments were the result of a joint

VA OIG and Postal Inspection Service investigation, which determined the individuals were engaged in a scheme to qualify veterans for in-home health care assistance and a VA pension by circumventing the system's income limitations. The trio devised an elaborate scheme whereby the veterans' service officer referred veterans to the home health care company by telling them they could qualify for both in-home aid and attendance as well as a VA pension. The individuals at the home health care agency would have a non-spouse family member or friend designated as home health care provider, making it appear that they were employees of the home nursing care company. The company would then establish fees for the designated care giver in the exact amount necessary to offset the veterans' household income regardless of the value or level of care provided. This process would cause the veteran to appear eligible for full VA pension benefits, which would then be paid to the veterans. A significant portion, however, was taken by the home nursing care company and shared with the veterans' service officer. The remainder of the funds was disbursed to the veterans and their spouses. This scheme resulted in a loss of over $300,000 to VA.

- Three individuals were arrested by special agents of the VA OIG and Postal Inspection Service based on a criminal complaint charging them with conspiracy to defraud the Government, after it was found they conspired to divert funds intended for the widow of a veteran. A joint investigation disclosed the individuals, one of whom was the daughter of the widow, continued to receive and negotiate VA pension benefit checks intended for the widow, after her death in 1997. Loss to the Government is approximately $8,000. The investigation continues.

- A veteran was indicted by a Federal grand jury on one count of making false statements. The indictment was the result of a VA OIG investigation, which disclosed the individual applied for and received VA pension benefits to which he was not entitled. Investigation showed he failed to report significant income and assets to VA, which would have made him ineligible for the benefits. Loss to the Government is more than $5,300.

- An individual was indicted on four counts of theft of Government property after the individual admitted during a VA OIG investigation that she wrongfully used VA pension benefits intended for her deceased father. She failed to notify VA of her father's death in 1994 and continued to access the funds that were electronically deposited for her father into their joint bank account. The loss to VA was more than $23,600.

- A criminal information and plea agreement were filed charging a veteran with one count of fraudulent acceptance of payments. A joint VA OIG and FBI investigation disclosed the veteran submitted false income verification reports to VA in order to qualify for pension benefits to which he was not entitled. The resulting loss to VA totaled more than $18,600. Sentencing is pending.

- A veteran pleaded guilty to one count of false statements. The guilty plea was the result of an indictment following a VA OIG investigation which determined the individual had made false statements regarding his total family income. As a result, he received $54,000 in pension benefits to which he was not otherwise entitled. Sentencing is pending.

- A veteran was sentenced to 8 months' imprisonment, 36 months' probation, and ordered to pay restitution of $59,780 following a guilty plea to charges of fraud against the Government. A joint VA OIG and SSA investigation disclosed that for almost 4 years, the individual fraudulently received VA benefits for a service-connected disability by declaring

himself unable to work. At the same time, he was fully employed, working under a false name and Social Security number to conceal the fraud.

- An individual was sentenced to 6 months' home detention, 5 years' probation, and ordered to make $37,200 in restitution to the Government. The sentencing was the result of a VA OIG investigation, which disclosed the individual used a false name and Social Security number to obtain VA pension benefits to which she was not entitled.

- An individual was indicted and subsequently arrested on charges of health care fraud, false use of a Social Security number, and theft of Government funds. A joint investigation by VA OIG, FBI, SSA, and VA police disclosed the individual, who was not a veteran, assumed the identify of a veteran, used the identifying data of the veteran, and filed fraudulent documents in order to receive VA medical treatment and pension benefits. As a result, the individual received over $147,000 in benefits to which he was not entitled.

Compensation Benefits Fraud

- The spouse of a deceased veteran was sentenced to 6 months' home detention, 2 years' probation, and ordered to pay restitution of $20,890 to VA and $26,435 to the Railroad Retirement Board (RRB) after she pleaded guilty to charges of theft of Government property. The sentencing was the result of a joint VA OIG, USSS, and RRB OIG investigation which disclosed that, at the time of his death in 1989, the veteran was using an alias, a fraudulent Social Security number, and false date of birth. Since his death certificate cited this fraudulent identifying data, neither VA nor RRB detected that the veteran was deceased and both agencies continued to issue benefit payments in his name. The spouse then converted these payments to her own use. In furtherance of this scheme, she had her son sign the veteran's name to yearly verification forms sent by both VA and the RRB. Based on the yearly submissions of these forms, benefits continued to be paid, resulting in a loss to the Government of approximately $51,000.

- A veteran was indicted by a Federal grand jury on one count of false statements and 10 counts of theft of Government funds. The indictment was the result of a VA OIG investigation, which charged that the veteran submitted false statements to VA in order to obtain increased benefits due to unemployability. As a result, he received over $72,000 in additional benefits to which he was not entitled.

- A widow of a veteran was sentenced to 12 months' home confinement, 2 years' supervised release, and ordered to pay restitution of $243,044 after having pleaded guilty to a one-count criminal information for theft of Government funds. A joint VA OIG and USSS investigation was initiated based upon information discovered during a VA computer records match. The investigation disclosed the individual, the spouse of a veteran collecting disability benefits for injuries sustained during his time of service in the U.S. Air Force, failed to report her husband's death in 1983. For more than 15 years, VA benefits continued to be sent in the husband's name. The widow continued to receive her deceased husband's monthly VA benefit payments, and wrongfully converted more than $243,000 in VA benefits to her own use.

- A veteran was arrested after she was indicted by a county grand jury on charges of felony theft. A joint VA OIG and USSS investigation revealed the veteran altered the figures on three VA compensation benefits checks, wrongfully obtaining $3,200 by this deception. Further judicial action is pending.

- A veteran pleaded guilty to conspiracy to defraud the United States and conspiracy to steal and convert VA and SSA funds pursuant to a criminal information that was filed. A joint VA OIG and SSA investigation revealed that, from 1987 to 1996, the veteran and his wife submitted false statements to VA and SSA regarding their income and marital status in order to receive both VA and SSA payments. The veteran's wife reported to SSA that she was single during that time, with no other income other than her SSA benefit payments, in order to continue receiving the benefits which would have terminated with remarriage. Further, after the couple divorced in 1996, the veteran failed to report the fact of the divorce to VA, which would have caused a reduction in VA benefits. As a result of these unlawful actions, the Government paid the couple more than $45,500 in benefit payments to which they were not entitled. According to the terms of the plea agreement, the Government agreed not to prosecute the wife for her part in the conspiracy.

Fiduciary Fraud

- An individual was arrested by VA OIG special agents after being indicted by a Federal grand jury for embezzling VA pension benefits intended for her mother. A joint VA OIG and Office of Personnel Management OIG investigation revealed the individual was appointed as her mother's fiduciary and court appointed guardian because her mother was disabled and unable to manage her VA benefits. Over a period of approximately 14 months, the daughter misappropriated over $10,000 in VA benefits while the mother was confined to a nursing home and supported by Medicaid.

- A nursing home administrator was sentenced to 15 months' imprisonment, 3 years' supervised release, and ordered to pay $45,000 in restitution. The sentencing and previous guilty plea resulted from a joint investigation by VA OIG, FBI, SSA OIG, and local police which determined the nursing home administrator, who had been appointed as fiduciary for three incompetent veterans residing at the home, embezzled funds from the veterans' bank accounts. The individual surrendered her state nursing home administrator's license upon entering the guilty plea. The state Attorney General is seeking revocation of her license.

- An individual was indicted on nine counts of wire fraud after a VA OIG investigation disclosed he embezzled funds from his ward, an incompetent veteran. The indictment charged that, over the course of approximately 3 years, the individual obtained more than $100,000 through fraudulent means. The individual executed a fiduciary agreement with VA, in which he agreed to serve as "custodian-in-fact" for the veteran. Pursuant to this agreement, he was required to use all money paid by VA strictly for the benefit of the veteran. Instead, however, the individual ordered interstate wire transfers of funds from the fiduciary account to several of his personal accounts.

- An individual serving as fiduciary for his cousin, a 100-percent disabled veteran unable to handle his benefits funds, was sentenced to 18 months' incarceration, 3 years' supervised release, and was ordered to pay restitution of $39,000 after a VA OIG investigation revealed the individual stole benefit monies intended for the cousin. As fiduciary, the individual was required to use the funds for the welfare of the veteran. The funds were deposited into a restricted-withdrawal agreement account. The account would not release any funds without required written authorization from VA. The individual forged VA authorization letters and illegally drained the account over a period of 3 months. The unauthorized withdrawals amounted to a loss of more than $39,000 in VA compensation benefits.

- An individual acting as a VA fiduciary, court-appointed guardian, and Social Security

representative payee to a number of elderly veterans was sentenced to 37 months' imprisonment, 3 years' probation, and ordered to pay restitution of $200,000 to her wards. The fiduciary previously pleaded guilty to charges of misapplication of funds by a VA fiduciary and mail fraud after an investigation by the VA OIG disclosed information that she had wrongfully appropriated funds belonging to the estates of five of her elderly veteran wards, some 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 individual was sentenced to 60 months' probation and ordered to pay $9,760 in restitution to VA, following a guilty plea to charges of fraudulent acceptance of payments. A VA OIG investigation disclosed the individual, a court-appointed guardian for a disabled veteran, failed to account for VA funds paid over a period of 14 months; funds he used for his own purposes.

- A former attorney, who was appointed to act as fiduciary for a World War II disabled veteran, was sentenced to 18 months' imprisonment, 3 years' probation, and ordered to pay restitution of $113,500 for theft of funds from the veteran's guardianship account. A VA OIG investigation disclosed that from 1990 to 1994, more than $120,000, which included Government benefits, was deposited into a bank account that the fiduciary had opened for the veteran. In late 1993, however, the fiduciary started withdrawing large amounts of money from the account to pay for personal expenditures.

Educational Benefits Fraud

- A former VARO education claims examiner was sentenced to 5 years' supervised probation, ordered to pay restitution of $6,119, and a fine of $500. The individual previously had pleaded guilty to an indictment charging her with one count of theft and embezzlement of Government funds. A VA OIG investigation determined she had used the identifying data of a veteran to submit forged and falsified educational benefits documents to VA, ultimately receiving more than $6,000 in benefits to which she was not entitled. Investigation disclosed she conspired with another education claims examiner and a veteran in a scheme that awarded educational benefits to the veteran even though he did not attend classes. The individual and the veteran split the money fraudulently obtained from VA. The other education claims examiner previously was indicted and pleaded guilty to the same charge. The veteran was charged for his role in the case and entered into a pretrial diversion program.

Laney College professor convicted in class-for-cash scam with veterans

[photo not available electronically]

- Two individuals were convicted on one count of conspiring to defraud VA and nine counts of aiding and abetting the making of false claims to VA, following a 5-week jury trial. The trial originally commenced involving 5 defendants: 3 former college professors and 2 student veterans, who were charged in a 25-count indictment with allegedly initiating a scheme in which student veterans received VA educational benefits without attending actual college classes. The student veterans allegedly paid instructors up to $50 per class, allowing them to attend weekly "symposiums" which fulfilled their requirements for up to four classes. These students received monthly educational stipends from VA because they were

perceived to be full time students. A joint VA OIG and Postal Inspection Service investigation has identified more than 550 veterans who participated in the fraud; about 450 of these veterans are involved in parallel civil proceedings. As a result of the civil settlements, the Government has recovered approximately $2.9 million.

Medical Benefits Fraud

- An individual was sentenced to one year of incarceration, 2 years' supervised release, and ordered to make restitution of $52,082 to VA after being arrested and subsequently indicted by a Federal grand jury on charges of theft of Government services. A VA OIG investigation disclosed the individual, who is not a veteran, falsified a military discharge form in order to make it appear that he had served in the military, thus enabling him to obtain medical care at a VAMC to which he was not entitled. Over a 5-year period the individual used the altered documents to receive over $285,000 worth of medical care to which he was not entitled.

- A VA OIG investigation found that an individual who has been a fugitive from the law for approximately 12 years, using multiple identities after having escaped from two Federal prison facilities, has been receiving VA compensation benefits while on the run from the law. According to the investigation, the individual has been receiving his benefits payments by electronic transfer to a bank account. He has also been receiving medical treatments at a VAMC on a regular basis. On the date of his last visit, VA OIG special agents assisted U.S. Marshals in arresting the individual as he reported for his scheduled appointment. Following his arrest, he refused to admit to using the identity listed on the arrest warrant. He is being held in custody for an identity hearing and then will be re-institutionalized at a Federal facility.

Other Benefits Fraud

- A civil complaint and consent decree were filed against an individual who served as National Service Officer for a Jewish War Veterans of America (JWV) office located at a VARO. A VA OIG investigation disclosed the individual contacted veterans who were going to be awarded retroactive compensation benefit checks for injuries suffered during their time in service. He advised them that, if they provided him with $1,000, he would help expedite their claims. Veterans were deceived into believing that paying the money would speed the processing of their claims and that, if they did not pay, the processing could be delayed indefinitely. The individual would collect and retain the money from the veterans, at times falsely representing to them that the money was being given to the JWV. The investigation identified 86 veterans who paid money to the individual. As a result of the investigation, he signed a civil consent decree in court admitting to the scheme. He turned over more than $93,000 to the Department of Justice, which will be used to reimburse his victims for his actions and pay related costs of the investigation. During the course of the investigation, he claimed he was the only individual involved in the scheme and resigned from his position with the JWV.

- A U.S. Marine and four family members were indicted on charges of conspiracy to defraud the United States. The Marine, his ex-wife, mother, and two brothers were all charged with making false claims in excess of $300,000 in attempts to obtain benefits from VA, Service Members Group Life Insurance, and SSA. The indictment charged that the five conspired in a scheme to fake the Marine's death in 1994 in a house-trailer fire, subsequently submitting false claims to the Government for benefits payments associated with the death. At the time of the house-trailer fire, the Marine was facing a court-martial in connection with the sexual assault of a

fellow Marine's daughter. Authorities claim he faked his own death to avoid prosecution and killed someone else as part of his scheme. Local police initially believed the burned body found at the scene of the fire was that of the Marine. The Marine was incarcerated awaiting trial on charges of murder, sexual assault, kidnapping, and arson. He also faced a court-martial by the U.S. Marine Corps for a host of charges ranging from desertion to sexual misconduct. He died in prison awaiting trial. Judicial actions are pending for the others involved.

- A veteran was arrested and charged in municipal court with one count of grand theft and five counts of forgery. A joint VA OIG and Federal Protective Service investigation disclosed the veteran, who was employed through a VARO's work-study program, was terminated from his employment at the work-study site due to misconduct. After his termination, he forged the initials of his former supervisor on his work-study time record and continued receiving compensation for hours that were never worked. Over the course of a 4-month period, the individual collected more than $1,700 in pay through these fraudulent means.

- An individual who served as president of a vehicle leasing company was sentenced to serve 5 to 15 years in the state penitentiary and was ordered to pay $549,053 in restitution. He previously was indicted on 24 counts of larceny, forgery, and making false statements, and pleaded guilty to 4 counts of grand larceny. A VA OIG investigation disclosed the individual, through his company, sold adaptive equipment vehicles to companies and individuals, some of which were purchased with VA funds for use by handicapped veterans. The company represented that it owned the vehicles outright when, in fact, it acquired the vehicles by lease and did not hold title to them. The company stopped making the lease payments after it sold the vehicles and, as a result, collection agencies began threatening to confiscate vans from the disabled veterans who believed they legitimately owned them.

National Cemetery Administration

Employee Integrity

- Two individuals formerly employed by VA, one as foreman and the other as caretaker at a VA National Cemetery, were sentenced on charges of witness tampering. The former cemetery foreman was sentenced to 6 months' home detention, 36 months' probation, and fined $2,000. The former caretaker was sentenced to 6 months' home detention, 36 months' probation, and fined $1,000. The sentencings were the result of a VA OIG investigation, which revealed the two individuals attempted to prevent witnesses from cooperating in a VA OIG investigation into corruption at the VA cemetery.

- A NCA program assistant was arrested on charges of theft of Government funds and conspiracy, pleaded guilty to a one-count indictment charging her with theft of Government property and ultimately resigned. At the time of her arrest, a search warrant was executed at her residence. A joint VA OIG and FBI investigation determined that a co-conspirator in the case, employed as a NCA program support assistant, used Government-issued purchase cards to purchase about $6,000 worth of merchandise for personal use. The merchandise included a television, camera, computer equipment, electronic equipment, and other items that she either sold for profit, gave to the program assistant, or kept for herself. The program assistant also used the second VA employee's Government-issued purchase card to pay a $1,400 past-due tuition bill for a relative. The second VA employee pleaded guilty to a

one-count criminal information charging her with the theft of more than $200,000 in Government property. Also arrested in the case was a sales representative for a company that contracted with the Government as an office supply vendor, after a warrant was issued charging him with bribery of Government officials and conspiracy to defraud the Government. During his interview, he admitted that he had provided cash and/or merchandise to the two VA employees in return for their making purchases from his company. He also admitted to obtaining a television from the former VA program support assistant, who had charged the item against her VA-issued Government purchase card.

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. A breakdown of laboratory examinations conducted during the period follows.

Laboratory Cases for the Period	
Requester	Cases Completed
OIG Office of Investigations	11
VA Regional Offices	4
Board of Veterans Appeals	2
VA Office of Regional Counsel	1
VA Regional Office & Insurance Center	1
TOTAL	**19**

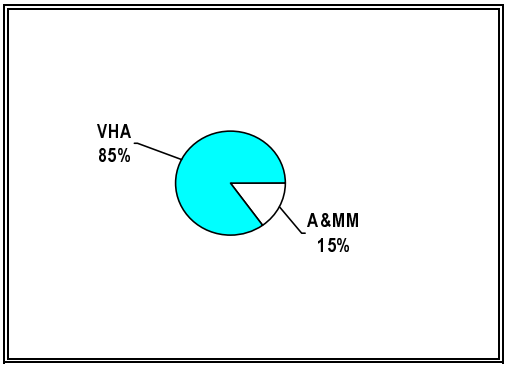
II. ADMINISTRATIVE INVESTIGATIONS DIVISION

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 15 cases, 5 of which had Congressional interest.

Output

- During the reporting period, 10 reports were issued. Five cases resulted in administrative closures.

Outcome

- VA managers took administrative actions against 8 high-ranking officials and other employees and 22 corrective actions to improve operations and activities as the result of these reviews, to include issuing bills of collection in four instances for collection of monies due VA.

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

Veterans Health Administration

Reliability of an Administrative Board of Investigation

A joint OIG review assessed the reliability of an internal Administrative Board of Investigation into the search for a patient and the recovery of his body. Our review concluded the Board did not adequately identify individual responsibility for a delay in recognizing the patient was missing and did not adequately assess the responsibility of individual police officers during the search for the patient. We also identified inadequate search policies and employee training and found the Board did not accurately assess some actions that occurred after the patient's body was found. Finally, we found management failed to assess the evidence adequately before taking administrative action against the employees involved. VHA officials agreed to correct weaknesses in accounting for patients' whereabouts. They also agreed to take administrative action against managers responsible for deficient local patient search policies and police officer training, and for proposing and sustaining disciplinary charges against nurses and police officers without ensuring the charges were adequately supported by the evidence. Finally, VHA officials agreed to review the appropriateness of the charges. *(Review of the Reliability of an Administrative Board of Investigation Concerning a Patient Search and Recovery, VA NJ Health Care System, Lyons Campus, 9PR-A01-110, 6/4/99)*

Contracting Issues

An administrative investigation substantiated that contracting officers and purchasing agents improperly awarded prohibited personal services contracts to two retired VA employees. As personal services contractors, these individuals were considered "employed" by the Government and were subject to restrictions regarding rates of pay and per diem reimbursement. VHA officials agreed to issue bills of collection for excesses in the rates of pay and per diem reimbursements and to work with the Office of Personnel Management to issue bills of collection to recoup the Federal retirement benefits the retirees received while under the personal services contracts. VHA officials also agreed to issue a bill of collection to one of the individuals to recoup the amount of the buyout she received. Finally, VHA officials agreed to take administrative action against the official responsible for issuing the contracts. VHA could not implement a recommendation to take administrative action against the facility director because he retired following issuance of our draft report. *(Contracting Issues at the VA Chicago Health Care System, Chicago, IL, 9PR-E03-143, 9/15/99)*

Procurement and Vehicle Use Issues

An administrative investigation substantiated that a senior official willfully misused a Government vehicle, improperly leased a luxury car for routine use, installed non-Federal plates

on the vehicle, illegally supplemented his Government salary, and was absent without taking leave. In response to our recommendations to take administrative action against the official for misuse of the vehicle, for supplementing his VA salary, and for unauthorized absences from duty and repeated tardiness, VHA officials proposed action and the official subsequently resigned. VHA officials also agreed to take administrative action against another official for improperly registering the luxury vehicle. They also agreed to terminate the lease of the vehicle, ensure that all the facility's vehicles had U.S. Government tags, and correct the senior official's improper leave records and travel claims. *(Procurement and Use of a Government Vehicle and Other Issues, VISN Boston, MA, 9PR-E11-114, 6/22/99)*

Time and Attendance Issues

An administrative investigation substantiated that a part-time physician violated time and attendance policy, which sometimes resulted in the physician being paid for hours not spent at the facility. VHA officials agreed to take administrative action against the physician, issue a bill of collection to recoup payments made to him for time not spent at the facility, and convert his appointment to an intermittent one. The investigation also substantiated that one of the physician's supervisors was aware of complaints about the physician's attendance pattern but took no corrective action. Administrative action against this official was previously taken. *(Time and Attendance Issues, VAMC Salisbury, NC, 9PR-A99-060, 6/22/99)*

Vehicle Lease Issue

An administrative investigation substantiated that a VHA Central Office official certified to the General Services Administration (GSA) that mid and large size vehicles were necessary for the new VISN offices, without first determining the actual needs. As a result of the unsupported certification, GSA authorized the VISNs to lease these vehicles. In at least two instances, the certification contributed to VISN offices wasting Government funds on unnecessary vehicles. As a result of this investigation, VHA officials provided VISN offices guidance requiring them to justify the vehicles they have acquired since 1996 and to obtain Central Office approval before leasing new vehicles or replacing existing vehicles with larger ones. VHA also reminded VISNs that, by regulation, all vehicles must be limited to the minimum body size and optional equipment required. *(Justification for the Lease of Non-Standard Passenger Vehicles by VHA, VA Central Office, 9PR-E11-057, 4/15/99)*

Office of Financial Management

Use of Local Supply Funds

An administrative investigation substantiated that three Office of Acquisition and Materiel Management (OA&MM) service chiefs did not ensure their travel expenses for a VA Central Office activity were charged to the appropriate funding source. They inappropriately charged their expenses to their stations' supply fund. As a result of this investigation, OA&MM officials reissued guidance, clarifying that only specified OA&MM employees may authorize travel for centrally directed supply fund programs and activities using the supply fund accounts. In addition, VHA officials corrected the erroneous charges. *(Use of Local Supply Funds for Travel by Various A&MM Service Chiefs, VA Central Office, Washington, DC, 9IQ-Q81-132, 8/11/99)*

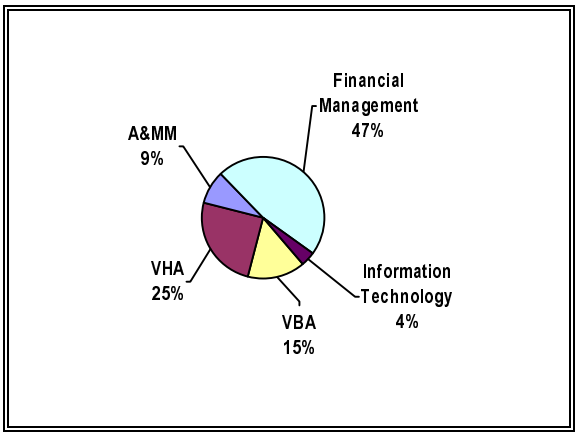
OFFICE OF AUDIT

Mission Statement

Improve the management of VA programs and activities by providing our customers with timely, balanced, credible, and independent financial and performance audits and evaluations that address the economy, effectiveness, efficiency, financial, and internal control of VA operations, and that identify constructive solutions and opportunities for improvement, and to conduct preaward and postaward reviews to assist contracting officers in price negotiations and to ensure reasonableness of contract prices.

Resources

The Office of Audit had an average 158 FTE assigned in VA Central Office and 7 operating divisions throughout the country during the 6-month period covered by this report. The following chart shows the percentage of resources utilized in auditing each of VA's major program areas.



In addition, the Office of Audit's Contract Review and Evaluation Division had 24 FTE reimbursed by the VA Office of A&MM. This Division conducts preaward and postaward reviews of certain categories of VA contracts.

Overall Performance

Output

- Issued 27 performance and financial audits and evaluations, for an output efficiency of 1 report per 3 FTE during this 6-month period. Additionally, 43 contract review reports (36 preaward contract reviews and 7 postaward reviews) were issued, for an output efficiency of about 3 reports per FTE for the 6-month period.

Outcome

- Recommendations were made to enhance operations and correct operating deficiencies with monetary benefits totaling $183 million. In addition, postaward contract reviews identified recoveries of $3.1 million; preaward contract reviews, designed to assist VA contracting officers in negotiating the best possible prices, made recommendations that should save VA $11.3 million.

Cost Effectiveness

- A return of $20 in monetary benefits was achieved for every dollar spent in performance and financial audits and evaluations during this 6-month period, $3 was recovered for every dollar spent on postaward contract reviews, and $51 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 4.2 on a scale of 5, for reports issued during the period. The average customer satisfaction rating for contract reviews was 4.7 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 Office of Information Technology. This is followed by an assessment of the implementation of GPRA in VA.

Veterans Health Administration

Resource Utilization

Issue: Management of employee quarters at VAMCs.
Conclusion: The quarters program is not needed and should be phased out.
Impact: Better use of $39.8 million.

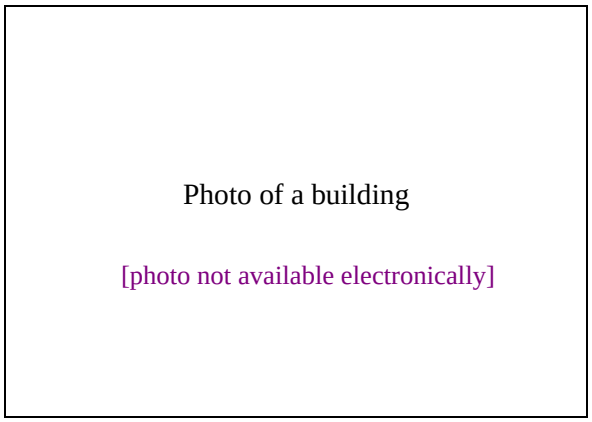
We evaluated how effectively VHA managed the employee quarters program. In FY 1997, 96 VAMCs operated 1,114 quarters units. We concluded that VHA should phase out the quarters program because it is not needed for VAMCs to accomplish their missions. Until this is done, VHA should address the following four issues.

First, VHA needed to discontinue implementation of the Quarters Management Information System (QMIS) as the method for setting quarters rents. For most VAMCs, QMIS yielded lower rents than those already established by appraisals. As a result, VHA's overall quarters rental income would be reduced by $962,000 a year and most rents would not be consistent with prevailing community rates as required by Federal policy.

Second, VHA needed to end the practice of deducting rent and utilities payments from the taxable compensation of certain employees. This practice did not meet the intent of Federal policy because the employees receiving the deduction were not required to live in quarters and because there was no mission-related need for the employees to occupy quarters.

Third, VAMCs needed to ensure that tenants were properly charged for utilities and other VA-provided services. VHA-wide annual undercharges for utilities and services totaled about $582,000.

Fourth, VHA needed to end the practice of making capital improvements on quarters that are not mission-essential. Over a typical 10-year period (the investment payback period used by VHA) VAMCs would spend about $38.25 million on improvements to unneeded quarters.



One of the VA Quarters reviewed in this audit.

We recommended that VHA: (i) discontinue the implementation of QMIS and return to using appraisals to set rents, (ii) require VAMCs with outdated or questionable appraisals to obtain new appraisals and set rents accordingly, (iii) end the tax deduction practice, (iv) require VAMCs to install utility meters and to charge tenants for metered usage, (v) issue guidance on charging for unmetered utilities and for other VA-provided services, (vi) issue guidance requiring that quarters capital improvements be

justified based on capital programming principles, and (vii) impose a moratorium on such improvements until the new guidance is issued. The Under Secretary for Health generally concurred with the recommendations and provided acceptable implementation plans or proposed acceptable alternative corrective actions. *(Evaluation of VHA Management of Employee Quarters at VAMCs, 9R8-A03-113, 6/18/99)*

"The direct involvement of your office has infused a number of top management initiatives designed to improve control and accountability of the resources involved in the operation of the rental quarters. This office looks forward to its continued partnership with your staff in the implementation of the recommendations."

Chief Facilities Management Officer

Issue: VHA radiology and nuclear medicine activities.
Conclusion: Standardized workload reporting and staffing guidelines, coordination in acquiring new technology, and greater oversight and direction was needed.
Impact: Better use of $114 million.

The purpose of this evaluation was to assess the effectiveness and efficiency of program operations. Based on results of a survey of 166 VA medical facilities, radiology and nuclear medicine services were appropriately accredited and all VAMCs reported that mammography services were offered to women veterans, either by in-house staff or by contract.

However, management attention was needed to improve specific operational areas. Radiology and nuclear medicine management information was reported inconsistently, preventing comparison and evaluation of medical center productivity. Staffing disparities existed among medical centers with comparable workloads and most radiology and nuclear medicine services did not apply staffing guidelines, or there was disparity in the guidelines that were used. We also found that the procurement of picture archiving and communication systems (PACS) equipment was not coordinated well by medical centers and VISNs, which could lead to inappropriate expenditures on incompatible PACS equipment totaling $114 million over the next 5 years. Finally, the Radiology Service program director position had been vacant since September 1996 and should be filled.

We recommended that: (i) management information reports and workload counting be made consistent, (ii) guidance be provided on the use of staffing guidelines, (iii) guidance be provided on the acquisition of picture archiving and communication systems equipment to assure need and compatibility, and (iv) a director of Radiology Service be appointed. The Under Secretary for Health concurred with our recommendations and provided acceptable implementation plans. *(Evaluation of VHA Radiology and Nuclear Medicine Activities, 9R4-A02-133, 7/23/99)*

"We very much appreciate the thoroughness and cooperative efforts of your evaluators, and believe that their observations accurately focus on opportunities for program improvement."

Under Secretary for Health

Issue: VHA's Emergency Medical Strategic Healthcare Group (EMSHG).
Conclusion: Improvements needed in determining VA's role in emergency management, fiscal accountability, interagency financial support, and training and development.
Impact: Better use of $4.6 million.

The audit was conducted at the request of the former VA Chief of Staff to determine if: (i) VA's emergency and disaster-related missions were properly established in legislation, interagency agreements, or other enabling action and were supported by published policies and procedures; (ii) these missions were properly a role for EMSHG; (iii) EMSHG's organization and supervisory structure and its organizational position within VHA served to achieve appropriate mission objectives; (iv) fiscal operations properly accounted for expenditures; and (v) management controls over headquarters and field staff were adequate. Audit results found programmatic inefficiency, ineffectiveness, and management turmoil.

We recommended the Under Secretary for Health: (i) determine what VA's role should be with respect to various Federal Government disaster programs, (ii) adjust EMSHG headquarters staffing levels, (iii) eliminate certain field positions and transfer essential duties to the VISNs, (iv) eliminate two specific EMSHG headquarters positions, (v) establish accounting mechanisms to track and account for expenditures and to identify and permit reallocation of unneeded funds, (vi) determine whether VA should continue to provide financial support to the National Disaster Medical System annual conference, and (vii) re-evaluate training and development activity.

We also identified two additional issues that needed VHA top management attention: (i) the functioning of EMSHG top management, and (ii) VA's ability to take on a proposed new emergency and disaster-related mission. The Under Secretary for Health concurred with all recommendations, with the exception of a deferred concurrence to one recommendation. *(Audit of the EMSHG, 9R4-A19-124, 6/28/99)*

"Your report appears to provide a thorough and candid evaluation of this important office, and I believe it will be very useful to us as we restructure this Strategic Healthcare Group."

Under Secretary for Health

Issue: Management of VAMC West Palm Beach.
Conclusion: Action is needed to resolve conflicts between the facility's top management team and a group of senior clinical staff.
Impact: Improved management and operations.

In response to a request by the Ranking Member, House Committee on Veterans' Affairs, we reviewed complaints and allegations of mismanagement made by VAMC clinical staff. We found that polarization existed between a group of senior clinical staff and the facility's top management team. We also found that several specific resource-related issues such as lack of control over spending for consultants and ineffective use of staffing resources were identified and addressed by facility and VISN management.

While budget and resource issues have contributed to the problems experienced at the facility, the polarization that existed between a core group of senior clinical staff and the facility's top management team was fundamentally the result of more complex factors involving expectations, personalities, and management style. We found there was a need

to ensure the facility's organizational goals were clear, communications were improved, and that management was responsive to the concerns of the clinical staff.

The Director, Florida/Puerto Rico VISN, concurred with our recommendations and provided acceptable implementation plans. *(Review of Hotline Complaints Concerning Issues Raised by Clinical Staff Questioning the Effectiveness of the Leadership and Management of the West Palm Beach VAMC, 9D2-A19-121, 8/12/99)*

Issue: VAM&ROC Togus.
Conclusion: Management action was taken to address concerns about the delivery of medical care and benefits within the state of Maine. Further action is necessary to increase cost-efficiency and effectiveness of operations.
Impact: Improved quality of care and better use of funds.

We conducted the audit in response to a request from the Maine Congressional delegation to perform an independent audit of funding, operations, and management issues. We found VAM&ROC management had addressed many of the delegation's concerns regarding the level and quality of service provided to veterans and beneficiaries living in Maine. For example: (i) additional community based outpatient clinics were opened in the communities of Calais and Rumford, Maine; (ii) most patients previously referred to facilities in Boston for magnetic resonance imaging and radiation therapy were now treated in Maine; (iii) five additional rating specialists were hired to expedite compensation and pension claims processing; and (iv) management had improved communication with stakeholders, including employees, veterans service organizations, and union representatives. We concluded the level of funds received by the VAM&ROC was commensurate with the level of funds received by other medical centers within VISN 1. We also found Togus generally ranked below other VISN 1 facilities in cost efficiency; also the utilization and productivity of some of its clinics could be enhanced. We concluded management should: (i) better control staffing costs - the indirect to direct staffing ratio ranked the highest in VISN 1 and among the highest in the nation; (ii) more closely monitor clinic utilization - only 5 of 11 clinics had most of their available appointments scheduled; and, (iii) implement pharmacy cost controls - the per patient drug cost for FY 1998 was VISN 1's highest and about 15 percent higher than the VISN 1 average.

Management concurred with the findings and recommendations, and provided an acceptable implementation plan. *(Audit of VAM&ROC Togus, ME, 9R1-F05-088, 5/3/99)*

Facility Management

Issue: Validation of construction projects.
Conclusion: Thorough reviews will enable better use of funds.
Impact: Better use of $20.4 million.

We conducted the audit to determine whether construction funds were managed effectively and were expended for projects that helped meet VA goals. Our audit included evaluations of: (i) the effectiveness of VAMC and VISN controls to ensure projects were justified and construction funds were used to meet agency goals, (ii) the methodology used to allocate funds to VISNs, and (iii) the timing of obligations.

We concluded that construction funds were managed effectively. However, some projects in the FY 1998 Operating Plan were not justified or

should be reduced in scope. This occurred because VAMC management did not always ensure that workload information and statistical data used to justify construction projects requests were current and accurate. Also, VAMC and VISN officials did not thoroughly review the scope and justification of projects.

We recommended the Under Secretary for Health ensure project justifications contained complete and accurate information. We also concluded a new methodology for allocating construction funds based on patient care workload should result in a more equitable distribution. The Under Secretary for Health agreed with our recommendations and provided acceptable implementation plans. *(Audit of VA's Minor Construction and Nonrecurring Maintenance Programs, 9R5-D02-118, 6/14/99)*

Fraud Detection

Issue: Workers' Compensation Program (WCP) protocol package.
Conclusion: Improved management.
Impact: Reduction in program costs.

We developed a protocol package to provide VISNs with an effective methodology to enhance review of claims and reduce annual costs. Our audit work shows that VA continues to be at risk for unnecessary WCP costs. Use of this protocol package should help VHA better identify potential fraud, waste, and abuse and reduce future costs. VHA's costs totaled about $133 million in charge back year 1998 and represent about 95 percent of VA's cost. During the last year, the OIG has been engaged in a review of VA's WCP. During this effort we have applied a three-step approach: a comprehensive national audit, a joint investigative/audit fraud detection effort, and the development of a protocol package.

The protocol package contains an automated analysis of claims as well as instructions on how to review WCP cases for identifying potential fraud. The automated analysis of claims provides a basis to prioritize cases for review and identify cases most likely to be fraudulent based on indicators developed during recent OIG initiatives in this program area.

Along with the protocol package, we also developed a case management and fraud detection handbook. The handbook contains information, instructions, and worksheets to aid individual VA facility WCP coordinators and specialists with case management and fraud detection efforts. The development of the protocol package and handbook was accomplished through a positive teaming effort with the Department. The OIG is committed to reducing fraud, waste, and abuse in VA's WCP and we will continue to work with the Department to enhance its review and oversight of claims. *(Protocol Package for VISN WCP Case Management and Fraud Detection, 9D2-G01-002, 4/14/99, and Handbook for Facility WCP Case Management and Fraud Detection, 9D2-G01-064, 4/14/99)*

Veterans Benefits Administration

Fraud Detection

Issue: Implications of employee thefts from the Compensation and Pension (C&P) system, and internal control vulnerabilities.
Conclusion: Significant vulnerabilities for fraud exist in the C&P program.
Impact: Improved internal control over C&P payments.

At the request of the Under Secretary for Benefits, we conducted an evaluation of internal controls in the C&P benefit program and

provided the Under Secretary our observations of vulnerabilities in the general internal control environment, and C&P claims processing in particular. The observations were derived from ongoing criminal investigations and a review of the control environment conducted by the Office of Audit. A nationwide evaluation of internal control has begun that will follow-up on the reported vulnerabilities, as well as any additional areas we decide should be included.

Delivery of Benefits and Services

Issue: VBA's customer service.
Conclusion: VBA has made good progress in implementing customer service standards.
Impact: Better service to VBA's clients.

The purpose of this evaluation was to assess progress in implementing customer service standards under the Government Performance and Results Act, to include measuring customer satisfaction, handling complaints, and providing improved access to VBA's toll-free customer service number. We found VBA management established customer service standards as required, but service could be further improved by: (i) fully implementing planned customer satisfaction surveys, (ii) establishing a customer complaint process, and (iii) providing improved access to VBA's toll-free customer service number. The Under Secretary for Benefits concurred with our assessment. *(Evaluation of VBA's Implementation of Customer Service Standards, 9R1-B18-127, 6/30/99)*

Loan Guaranty

Issue: Mortgage lenders compliance with VA underwriting standards.
Conclusion: Lenders followed VA guidelines in most cases.
Impact: Reduce VA home loan defaults.

As part of an ongoing national audit, we audited two mortgage lenders to assess compliance with VA underwriting standards. The purpose of the reviews were to determine if the lenders had complied with VA requirements in underwriting loans that subsequently went into default. We found the loans originated by both lenders generally complied with VA underwriting guidelines. Three loans (two at one lender and one at the other lender) were not underwritten appropriately because the applicants would not have met minimum VA criteria if the guidelines had been accurately applied. However, the deficiencies did not warrant indemnification because there was no evidence of fraud or misrepresentation. The Director, VARO Atlanta, who has jurisdiction over VA home loan processing in North Carolina and Alabama, concurred with our recommendation to discuss these discrepancies with the lenders' officials and provided acceptable implementation plans. *(Underwriting Practices, Carolina Mortgage Company of Fayetteville, NC, 9R5-B10-099, 5/6/99, and Underwriting Practices, Southtrust Mortgage Corporation, Birmingham, AL, 9R5-B10-123, 6/23/99)*

Office of Financial Management

VA's Financial Statements

Issue: Public Law 104-208 Financial Management Improvement Act of 1996.
Conclusion: VA did not comply with certain Act requirements.
Impact: Improved stewardship of VA assets and resources.

Our report on VA's Consolidated Financial Statements (CFS) for FYs 1998 and 1997 describes noncompliance with Federal Financial

Management Improvement Act requirements concerning Housing Credit Assistance program financial management information systems, information system security, cost accounting standards, and provisions of the Credit Reform Act as it relates to guarantees on Housing Credit Assistance loans sold. Remedial actions taken by the Department to bring these areas into compliance are also described. Except for these instances of noncompliance, we concluded that for the items tested, VA complied with laws and regulations materially affecting the financial statements. *(Audit of VA's Consolidated Financial Statements for FY 1998, 9AF-G10-061, 3/10/99)*

Issue: Financial management.
Conclusion: Six 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 six management letters addressing financial reporting and control issues. The management letters provided Department managers additional observations and advice that will enable the Department to improve accounting operations and controls. These issues included: (i) expenditure transactions, (ii) automated data processing (ADP) security, and (iii) VBA benefit programs.

None of the conditions noted had a material effect on the FY 1998 CFS, but correction of the conditions was considered necessary for effective operations. Where needed, appropriate adjustments were made to the financial statements. *(Management Letter: Expenditure Transactions, 9AF-G10-086, 4/15/99; Management Letter: ADP Security at Philadelphia Regional Office and Insurance Center and Benefit Delivery Center, 9AF-G10-087, 4/22/99; Management Letter: ADP Security at Hines Benefit Delivery Center, 9AF-G10-098, 5/6/99; Management Letter: ADP Security at VHA, 9AF-G10-097, 5/13/99; Management Letter: FY 1998 Financial Statements, VA Life Insurance Programs and Selected Loan Guaranty Program Financial Activities 9R1-G10-100, 5/21/99; Management Letter: ADP Security VBA, 9AF-G10-106, 6/1/99; and Management Letter: FY 1998 Consolidated Financial Statement Audit – Benefit Programs, 9R4-G10-116, 6/14/99)*

"We appreciate your office's work in accomplishing the FY 1998 audit. The audit, a real joint management and OIG effort, made and will continue to make a difference to the Department."

Deputy Assistant Secretary for Finance

Issue: Financial management.
Conclusion: VA's Enterprise Centers' financial statements present their financial position fairly.
Impact: Financial reporting and control.

VA's Franchise Fund supports VA's mission by supplying common administrative services at competitive prices to Federal entities. Congress created the Fund in 1996 as one of six Franchise Fund pilots operating within the executive branch of Government. In FY 1998, the Fund included six Enterprise Centers (lines of business): the Austin Automation Center, Financial Services Center, Law Enforcement Training Center, Computer Training Center, Security and Investigations, and the VA Records Center and Vault.

The audit of VA's Enterprise Centers financial statements by an independent public accounting firm concluded the statements present fairly, in all material respects, the financial position of the Centers. No material weaknesses were found in the internal controls tested. However,

improvement was needed in certain internal controls related to year-end accrual procedures. This weakness, although not considered to be material, represented deficiencies which could adversely affect the Centers' ability to meet internal control objectives. No reportable noncompliance with laws and regulations were found in areas tested. *(VA's Enterprise Centers Financial Statement Audit for the FY Ended September 30, 1998, 9AN-G10-117, 6/22/99)*

Postaward Contract Reviews

Issue: Contractor overcharges for x-ray film, medical equipment, and supplies.
Conclusion: Postaward reviews disclosed overcharges.
Impact: Recovery of $2.8 million.

- A medical and dental x-ray film and supplies manufacturer remitted $1.4 million to VA, in addition to the $516,000 previously paid to VA. Contract overcharges resulted from the manufacturer not disclosing accurate, complete, and current pricing and discount information to the contracting officer during negotiations and the failure to comply with provisions of the Price Reduction clause. The contractor's failure to disclose to the contracting officer that it offered more favorable pricing to other commercial customers denied the Government the opportunity to negotiate better discounts.

- VA recovered $1,252,869 from a medical equipment manufacturer for contract overcharges that resulted because the manufacturer did not disclose accurate, complete, and current pricing and discount information to the contracting officer during negotiations. The contractor's failure to accurately disclose the nature and extent of promotional pricing practices on accessories denied the Government the opportunity to negotiate promotional prices. Our review showed that the contractor typically sold most accessory items at promotional pricing.

- A medical supplies company remitted $108,952 to VA for an aggregate end-of-contract rebate for FSS sales.

- A medical equipment cost-per-test contractor remitted $8,457 to VA for contract overcharges related to inadvertent overbillings to VAMCs.

Issue: Contractor overcharges for pharmaceuticals.
Conclusion: Postaward reviews and surveys disclosed overcharges.
Impact: Recovery of $306,000.

- We completed 26 Public Law 102-585 compliance reviews and surveys. For 11 of the 26 reviews and surveys, errors in the calculation of Federal Ceiling Prices resulted in contract overcharges. The companies agreed to pay $306,291 to VA. Of the 11 reviews and surveys with recoveries, 6 were related to voluntary disclosures and refund offers. Where appropriate, we made recommendations to 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.

Preaward Contract Reviews

Issue: Federal Supply Schedule vendors did not offer best prices.
Conclusion: Contractors can offer better prices to VA.
Impact: Potential better use of $11.3 million.

- A preaward review of a medical supplies company's offer resulted in potential contract

savings of $9,124,049. The estimated 5-year contract value was $85 million.

- A preaward review of a medical equipment company's offer resulted in potential savings of $1,127,908. The estimated 5-year contract value was $8.7 million.

- A preaward review of a medical supplies company's offer resulted in potential savings of $675,376. The estimated 5-year contract value was $45 million.

- Three preaward reviews of medical equipment and supplies companies' offers resulted in potential savings of $364,461.

Office of Information and Technology

Issue: VA's Year 2000 (Y2K) implementation efforts.
Conclusion: Efforts were well organized and focused on mission critical systems. However, additional effort is needed in other selected areas.
Impact: Continuity of operations in the Year 2000.

The purpose of the audit was to assess VA's efforts to address Y2K computing issues and become Y2K compliant. The audit focused on identifying areas where VA's Y2K implementation efforts could be strengthened. The audit found VA's Y2K efforts were well organized and focused on those mission critical systems that must be compliant to ensure veterans receive uninterrupted services. VA management reports show it completed implementation of all mission critical systems by the March 31, 1999 milestone date established for all Federal agencies.

The audit identified a number of issues to address that could help make the Department's overall Y2K efforts more successful, reduce operating costs, and ensure continuity of operations beyond the millennium. Key areas that needed to be addressed included: (i) infrastructure support; (ii) contingency planning; (iii) assuring computers, biomedical devices and equipment provided to veterans for home use were Y2K compliant; and (iv) approval of pending requests for equipment and software replacements that would reduce operating costs by $1.5 million and enhance Y2K implementation efforts. Because of the high risk associated with failure to comply, the Department should continue to monitor Y2K risk as a potential material weakness area.

The Acting Assistant Secretary for Information and Technology concurred with the report findings, recommendations, and monetary impact figures and provided appropriate implementation actions. *(Audit of VA's Year 2000 Implementation Effort, 9D2-G07-049, 6/10/99)*

"We appreciate the effort you and your staff have made in conducting site visits to VA's medical centers and regional offices."

"Your continued assistance in conducting site visits will assist my office in overseeing VA's Year 2000 efforts."

Acting Assistant Secretary for Information and Technology

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

During this 6-month reporting period, we assessed the accuracy of data used to measure the percent of veterans with a VA burial option and the accuracy of data used to count the number of unique patients.

National Cemetery Administration Burial Option

One of VA's goals is to ensure that all eligible veterans have reasonable access to a VA burial option. Audit results showed that NCA personnel generally made sound decisions and accurate calculations when preparing their estimate. However, the Office of Program and Data Analyses personnel could not re-create the veteran population projections which were used to calculate NCA's estimate because certain essential data were no longer available. The lack of this data impaired the scope of our audit and as a result, we could not verify the accuracy of the population projections or the NCA estimate which was based on the projections. We recommended that the Office of Program and Data Analyses retain sufficient documentation to re-create future veteran population projections.

The Assistant Secretary for Planning and Analysis agreed with our recommendations and provided acceptable implementation plans. The NCA Office of Operations and Support provided comments that indicated corrective action would be taken for the concerns we noted in the management advisory section of the report. We consider the recommendations resolved.

Unique Patients Using VA Medical Centers

VHA's GPRA performance measure - Number of Unique Patients - needs more accurate data. We found that the 3 million unique patients reported for FY 1997 overstated actual usage by 5.7 percent. The overstatement occurred because: (i) inaccurate Social Security numbers were input into the national patient care data base, and (ii) patients with undocumented outpatient appointments and appointment cancellations and no-shows were sometimes counted as being treated.

To correct the overstatement, we recommended the Under Secretary for Health establish an edit check at the Austin Automation Center to identify and correct input errors, establish an edit check to identify pseudo Social Security numbers, and make corrections if necessary. The Acting Under Secretary for Health agreed with the recommendations and provided acceptable implementation plans.

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 four VHA performance measures and one VBA performance measure. These measures are:

VHA Performance Measures -

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

VBA Performance Measure -

- Foreclosure avoidance through servicing.

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

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

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

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

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

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

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

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

OFFICE OF HEALTHCARE INSPECTIONS

Mission Statement

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

Resources

The Office of Healthcare Inspections (OHI) has 31 FTE allocated to staff headquarters and field operations. Three regional offices have been established in Atlanta, Chicago, and Los Angeles. OHI staff are deployed 100 percent in healthcare inspections and evaluation issues.

Overall Performance

Output

- We published 19 final reports during the reporting period.

Outcome

- We made 44 recommendations, focused on improving both clinical care delivery and management efficiency.

Customer Satisfaction

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

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 related projects and reports. These projects included reviews of VHA's missing patient policies and procedures, an analysis of the Defense and Veterans Head Injury Program operations, and a nationwide review of VHA's Deans Committee structure, functions, and compliance. With the development of a more deliberative and stringent process for selecting and assigning Hotline allegations, we have improved our ability to complete and report on these reviews more promptly. The quality program assistance (QPA) review is now included as an integral part of the Combined Assessment Program, but we will continue to use it as a tool for inspecting sensitive Hotline allegations at VAMCs.

Veterans Health Administration

Nationwide Healthcare Program Reviews

Issue: VHA's responsibility to oversee and evaluate its policy on missing patients.

Conclusion: Improvement is needed in the monitoring of high-risk patients and in patient search procedures.

Impact: Ability to ensure patient safety and improve health care.

In keeping with our oversight responsibility of contributing to the improvement of health care delivery, we conducted an exploratory and preliminary assessment of VAMCs' missing patient policies and procedures. Patients leaving VAMCs without approval or knowledge of clinicians has been an issue that has instigated various reviews and constituent concerns. Moreover, incidents of patients missing or eloping from VAMCs can result in such consequences as serious injury or death, which undermine the public's perception of the quality of care provided to veteran patients.

We recognize that VAMCs face a difficult challenge in securing high-risk patients in view of the delicate balance of maximizing patients' rights in the least restrictive environment, while at the same time ensuring patient safety. However, several patient incidents have raised concern regarding the process of granting privileges to patients who may be at risk for eloping and the adequacy of VAMC search procedures when patients disappear from the treatment area.

Our analysis showed that: (i) improvement is needed in monitoring high-risk patients, and in patient search procedures, to further reduce adverse patient incidents that result from unauthorized absences; and (ii) clinical managers, who have responsibility for ensuring patient safety, need to assess and record appropriately the factors that can help define a patient's elopement risk. These factors, when communicated in the treatment planning phase, are essential clinical information, which can be used for granting privileges to patients, and help reduce the risk of patient unauthorized absences.

The Under Secretary for Health agreed with our conclusions and suggestion. *(Preliminary Assessment of VHA's Missing Patient Search Procedures, 9HI-A28-084, 4/8/99)*

Issue: Administrative and clinical operations of the traumatic brain injury program.
Conclusion: Program is innovative, widely needed, and generally effective.
Impact: Better management and care of brain injured patients.

Head injury is a major medical and social problem for both active duty personnel, who are served by the DoD health care system, and for U.S. veterans, who are served by VA. In 1992, VA and DoD joined to establish the Defense and Veterans Head Injury program in order to better manage traumatic brain injured patients. Coordination of this jointly operated program appears to be effective. The program is mutually beneficial to both Departments and to their beneficiaries.

Our analysis showed VA is an active component of the joint program operations and that VHA clinicians are treating a broad range of head-injured patients, including evaluating and treating acute head injuries. We found that VHA's four lead traumatic brain injury treatment centers (Richmond, Tampa, Minneapolis, and Palo Alto), with some exceptions, offer comprehensive head-injury care. However, the secondary centers vary tremendously in the scope of services they offer.

We concluded that clinicians need to strengthen coma care, refine the treatment of violent patients, and strengthen support of ventilator-dependent patients. VHA managers need to increase system-wide awareness of the program, particularly as VHA continues its transition to a primary health care model. The Under Secretary for Health agreed with our conclusions and recommendations that are aimed at strengthening this valuable program. (*Oversight Review of Selected Aspects of VHA's Traumatic Brain Injury Program, 9HI-A28-119, 4/30/99)*

Issue: Is the Deans Committee functioning effectively?
Conclusion: Deans Committees do not appear to fulfill their original purposes and functions.
Impact: Weakened coordination of university and VA contributions to the delivery of care.

We conducted this nationwide assessment of the VHA's Deans Committee structure, functions, and compliance with established VHA policy guidance. We sent structured questionnaires to 136 VA medical centers that reportedly have academic affiliations with medical schools. We

requested information about individual medical center compliance with VHA Deans Committee guidance and also requested a representative sample of each medical center's Deans Committee minutes. We performed a comparative analysis between individual medical center manager's perceptions of their Deans Committee's compliance with VHA's requirements, and the results of our review of each of the sets of minutes that medical center managers sent to us.

We found that, over time, the Deans Committee structure and function have changed as result of affiliation governance. This has occurred based on the emergence of VISN-stimulated changes in VHA's academic affiliation program and the governance of the affiliation relationship, as exemplified by the Deans Committee. VHA developed a revised approach to the governance of its academic affiliations with the establishment of Academic Partnership Councils. VHA is shifting toward a VISN-wide role for the administration of these academic affiliations and the implementation of Affiliation Partnership Councils.

As VHA continues its evolution from Deans Committees to Affiliation Partnership Councils, VHA top managers need to more stringently oversee Council functions to ensure that they adhere to law and VHA guidance. VHA also needs to revise its policy to standardize guidance for Council operations. The Under Secretary for Health concurred with our recommendations and provided responsive implementation plans. *(Review of the Policy and Function of VHA's Deans Committees for Academic Year 1996, 9HI-A28-145, 8/11/99)*

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.

Impact: Developing initiatives to provide good, accessible care at an affordable cost.

During this reporting period, OHI completed one QPA review. OHI inspectors concluded that medical center executive managers were working collaboratively 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.

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. Patients had generally positive impressions about recent improvements in care, accessibility, and employee attitudes that occurred in association with the changes. Executive managers established intensive communication initiatives to keep employees and other stakeholders fully informed about ongoing and contemplated organizational and operational changes. *(Quality Program Assistance Review, VAMC Baltimore, MD, 9HI-F03-107, 5/13/99)*

Healthcare Hotline Inspections

Issue: Alleged substandard care of three nursing home patients at VAMC Tuskegee.
Conclusion: A piece of Foley catheter remained in a patient's urethra for 11 days after the catheter was removed.
Impact: Vague procedure guidance can lead to untoward patient incidents.

We inspected allegations of substandard care made by a complainant at the Tuskegee Nursing Home Care Unit (NHCU). We substantiated one of the complainant's three allegations that a piece of Foley catheter remained in a patient's urethra for 11 days after the catheter was removed. We could not substantiate allegations that two other patients received improper treatment. We made several recommendations to address the issues that we identified. The Medical Center Director concurred with the recommendations and implemented or planned appropriate corrective actions. *(Inspection of Alleged Poor Quality of Care of Three Nursing Home Care Patients, VA Central Alabama Veterans Health Care System, East Campus, Tuskegee, AL, 9HI-A28-091, 4/28/99)*

Issue: Alleged inadequate treatment at VAMC Denver.
Conclusion: Clinicians used all possible resources to provide the patient with the care he required.
Impact: Continued quality health care.

A complainant alleged that clinicians refused to perform a needed aortic valve replacement on his father (the patient), and that clinicians refused to transfer the patient to another hospital which would perform the operation. The complainant also alleged that physicians never returned telephone calls to private sector physicians who were willing to accept his father, and the patient was not provided with appropriate treatment while he was hospitalized at the VAMC.

We concluded that VAMC physicians provided the patient with appropriate care. Clinicians did not perform an aortic valve replacement on the patient, but this was a justifiable and appropriate clinical decision. We did not confirm that medical center officials refused to comply with the family's request to transfer the patient to another hospital. The patient's multiple medical problems precluded any open-heart surgery. Clinicians used all possible resources to provide the patient with the care he required.

The complainant was often not receptive to VAMC employees' attempts to communicate with him regarding the patient's medical conditions and realistic treatment options. Several VAMC clinicians were concerned for their safety because of the complainant's irrationality. When the patient's illness did not progress as expected, the complainant's aggressive behavior and inappropriate reactions concerned VAMC employees. We did not identify any problems in the patient's treatment and did not make any recommendations. *(Inspection of Inadequate Treatment for Aortic Stenosis, VAMC Denver, CO, 9HI-A28-092, 4/28/99)*

Issue: Allegations of undetected death and elopement and death of psychiatric patients at VAMC Northport.
Conclusion: Allegations were not substantiated.
Impact: Medical Center's policy and procedures are adequate.

A Congressman asked us to inspect the alleged circumstances surrounding: (i) a patient who died at the NHCU without employees detecting the death for 24 hours, and (ii) a patient who was found dead on the hospital grounds a considerable time after he disappeared from the

treatment environment. This inspection was done coincident with a broader inspection of general allegations pertaining to other clinical and administrative discrepancies on the VAMC's long-term care and chronic psychiatry areas.

We did not find any indication that a patient had died in the NHCU and that clinicians were not aware of the death for 24 hours. NHCU nurses make patient rounds and observe patients for respirations and safety every 1 to 4 hours. None of the nurses or other employees whom we interviewed were aware of any incident in which a patient had died, and whose death had not been discovered for an excessive period of time. We concluded that this alleged event did not occur.

As for the second allegation, medical center managers acknowledged that employees found a deceased veteran in a wooded area on the medical center campus. While we confirmed that a veteran was found dead on VAMC grounds, we did not find any evidence to suggest that employees had provided the patient with anything less than adequate care during his inpatient and outpatient episodes of care.

The veteran's wife had dropped the veteran off on VAMC grounds because he wanted to live there, apart from his family. We could not find any evidence that he ever saw a clinician or any other employee on that day. He was subsequently found dead in the wooded area. Clinical managers conducted a thorough morbidity/mortality review of the circumstances surrounding the patient's death. We concluded that a medical center-initiated search would not have been indicated, because the patient was not an inpatient at the time of his disappearance, did not have a clinic appointment, and apparently did not apply for treatment on the day that his wife delivered him to the VAMC.

It was the patient's family's responsibility to report the patient's disappearance to the local police department and to request a search. Since we did not find any indications that employees acted improperly, or that faulty internal procedures led to the patient's disappearance, we did not make any recommendations. *(Inspection of Alleged Undetected Nursing Home Patient's Death, and Alleged Elopement and Subsequent Death of a Psychiatric Patient, VAMC Northport, NY, 9HI-A28-104, 5/13/99)*

Issue: Allegations of inadequate care and denial of patient rights at VAMC Northport.

Conclusion: Allegations were not substantiated.

Impact: Effective communication can lead to improved interaction with patients.

The Office of Medical Inspector asked OHI to inspect a patient's complaint in the context of our broader inspection of medical center operations. The complainant alleged that VAMC clinical managers implemented a healthcare agreement that violated his rights and that the patient representative did not assist him in contesting the agreement. The complainant also alleged that another patient died because of inadequate care in the NHCU.

An OHI inspector and a consultant, who has expertise in mental health care, inspected the complaint. We did not substantiate either of the two allegations. We concluded: (i) the complainant's history of threatening behavior warranted the behavioral agreement, and (ii) clinicians had appropriately treated the deceased NHCU patient and managers properly reviewed his clinical care.

We made two suggestions that, if implemented, would improve the complainant's compliance with his health care agreement. The Medical Center Director concurred with our recommendations and cited significant improvement in interactions between the

complainant and staff. (*Inspection of Alleged Denial of a Patient's Rights, VAMC Northport, NY, 9HI-A27-108, 5/17/99)*

Issue: Alleged poor quality of care on the Dialysis Unit at VAMC St. Louis.
Conclusion: Employees had attached patients' reusable dialyzers to the wrong dialysis machines, but they properly reported the incident, and took appropriate actions to ensure the patients' welfare.
Impact: Safeguards developed to reduce errors.

An anonymous complainant alleged that: (i) employees had been verbally abusive and threatening; (ii) hemodialysis unit patients were dying because of inadequate dialysis treatments; (iii) the dialysis program medical director refused to provide medication refills to patients if they missed appointments; (iv) technicians were not appropriately sterilizing the hemodialysis machines, which resulted in the transmission of infections to patients; and (v) patients' reusable dialyzers had mistakenly been attached to other patients' dialysis machines.

The first four allegations were not substantiated. We substantiated the allegation that employees had attached patients' reusable dialyzers to the wrong dialysis machines. One such incident had occurred several years ago in which clinicians mistakenly interchanged two patients' sterilized reusable dialyzers and inadvertently attached these dialyzers to the wrong patients' dialysis machines. The incident did not result in any patient harm. We did not identify any similar incidents and we concluded that managers had initiated adequate preventive safeguards to reduce the possibility of reoccurrence. The employees who were involved in the incident had promptly and properly reported the incident, and managers took appropriate actions to monitor and ensure the patients' welfare. *(Inspection of Alleged Poor Quality of Care in the Dialysis Unit, John Cochran Division of the VAMC St. Louis, MO, 9HI-A28-109, 5/17/99)*

Issue: Alleged mismanagement of Pharmacy Service and substandard patient care at the VA San Diego Healthcare System.
Conclusion: Three untoward patient care events and one adverse drug reaction had occurred.
Impact: Strengthened reviews and oversight will improve patient care and reduce errors.

A California Congressman and the House Committee on Veterans' Affairs requested the OIG inspect multiple allegations of Pharmacy Service mismanagement and 10 episodes of alleged substandard patient care. A senior pharmacy manager who is assigned to another VISN consulted with OHI inspectors on Pharmacy Service management issues.

We confirmed that three untoward patient care events and one adverse drug reaction had occurred among the 10 alleged cases of substandard care. We did not substantiate the remaining six cases.

Quality managers and executive managers had identified and thoroughly reviewed each case of untoward care when it occurred and instituted appropriate corrective actions. Therefore, we did not make any recommendations. We did not substantiate any of the allegations pertaining to flawed Pharmacy Service management practices, and we did not make any recommendations concerning these issues. *(Inspection of Multiple Allegations of Pharmacy Service Mismanagement and Substandard Patient Care, VA San Diego Healthcare System, San Diego, CA, 9HI-A28-112, 5/26/99)*

Issue: Alleged substandard and unprofessional care.
Conclusion: Allegation not substantiated.
Impact: Appropriate delivery of care to patient with history of substance abuse was confirmed.

A complainant alleged that he received substandard care and unprofessional treatment when VAMC Biloxi clinicians made him wait for excessive periods of time in the Emergency Room and denied him pain medication. The complainant alleged he contracted hepatitis B as a result of a blood transfusion that he received. The complainant further alleged that he contracted hepatitis C and sustained back, knee, and neck injuries when a patient struck him on the head while he was employed at the VAMC.

We did not substantiate any of the allegations. We concluded that medical center clinicians promptly evaluated the complainant's medical treatment concerns, and that a physician prescribed pain medication to alleviate his complaints of chronic pain, even though he had a history of drug seeking behavior. We concluded the physician's decision to order these analgesic drugs was within the standards of community practice. *(Inspection of Alleged Substandard Care and Unprofessional Treatment, VA Gulf Coast Veterans Health Care System, Biloxi, MI, 9HI-A28-128, 6/29/99)*

Issue: Alleged patient abuse.
Conclusion: Employees acted properly in restraining a patient. A psychologist operated outside the scope of practice.
Impact: Establishment of a Process Improvement Team to evaluate the overall mental health practices related to emergency psychiatry.

A complainant alleged that a VAMC Biloxi employee pushed down on a patient's throat during a physical takedown in the VAMC's Emergency Room, causing irreversible physical damage. We did not substantiate the allegation. We concluded that employees did restrain the patient when he became agitated and bit an employee on the hand. However, we could not conclude that employees' actions in restraining the patient caused irreversible physical damage.

The psychologist involved in the patient's Emergency Room evaluation ordered the use of restraints. Such an order is not within a psychologist's scope of practice. The psychologist also failed to determine if the patient was incompetent to make medical decisions and failed to document a competency determination in the patient's medical record. The patient did not give consent for his hospitalization. The psychologist failed to initiate actions for commitment procedures for involuntary hospitalization and failed to document this in the patient's medical record. Managers initiated a series of corrective actions to clarify the privileges of non-medical clinicians and to review policies and procedures for Emergency Room mental health services. *(Inspection of Alleged Patient Abuse, VA Gulf Coast Veterans Health Care System, Biloxi, MI, 9HI-A28-129, 6/29/99)*

Issue: Operational deficiencies at the Ventnor, NJ Outpatient Clinic.
Conclusion: Staffing levels are inadequate to meet psychosocial and health care needs of veterans.
Impact: Poor clinic conditions and interpersonal relationships.

An anonymous complainant alleged operational deficiencies were adversely affecting patient care at the clinic. OHI inspectors visited the Wilmington VAM&ROC and the clinic. Inspectors found interpersonal communications among clinicians and other employees are inadequate to meet patients' needs. Clinic staffing levels are inadequate to meet the

psychosocial and health care needs of the local veteran population. There is no evidence in the medical records that we reviewed that the nurse practitioner provided substandard care.

We made two recommendations aimed at improving clinic conditions and interpersonal relationships. The Medical Center Director concurred with our recommendations and provided acceptable implementation plans. *(Inspection of Alleged Ventnor, NJ Outpatient Clinic Deficiencies, VAM&ROC Wilmington, DE, 9HI-A28-130, 6/30/99)*

Issue: Alleged misdiagnosis and failure to properly treat a patient's liver cancer.
Conclusion: Clinicians initially misdiagnosed the cancer, but sought clarification from the Armed Forces Institute of Pathology.
Impact: Stronger review of biopsy findings.

The family of a patient made several allegations including misdiagnosis of the patient's liver cancer, failure to properly treat the patient's liver cancer, failure to completely excise a tumor on the patient's scalp, and mismanagement of the patient's fluid retention medication.

We concluded that VAMC Madison clinicians initially misdiagnosed the patient's liver cancer. The biopsy slides were sent to the Armed Forces Institute of Pathology (AFIP) for a second opinion and AFIP pathologists made the diagnosis of hepatocellur carcinoma (liver cancer) one month later. The surgeons could not safely completely excise the patient's scalp tumor, but they removed a sufficient amount of the lesion to provide palliation. Further resection of the tumor could have resulted in severe and possibly fatal complications.

There is no evidence in the medical records that clinicians failed to properly treat the patient's liver cancer, or that they mismanaged the medication prescribed for the patient's fluid retention. We recommended the Medical Center Director ensure the appropriate service chief monitor biopsy interpretations to ensure the accuracy of pathology findings. The Director concurred with our recommendation and implemented corrective action. *(Inspection of Alleged Poor Quality of Care, William S. Middleton Memorial Veterans Hospital, Madison, WI, 9HI-A28-137, 7/30/99)*

Issue: Patient falls.
Conclusion: Clinical managers had not established safety measures to protect incompetent patients from wandering.
Impact: Strengthened patient surveillance and evaluation practices will improve patient safety.

A complainant alleged that two patients experienced serious falls at the NHCU at the Central Alabama Veterans Health Care System, Tuskegee, AL. These two patients were reportedly incompetent and in their wheelchairs when they fell down the stairs.

We substantiated the allegations that the two patients, both of whom had diagnoses of dementia, fell down a stairwell in their wheelchairs. Managers believed that, in the first case, someone had propped a stairwell door open, thus allowing a patient to roll down the stairs. In the other case, clinicians had not properly assessed an incompetent patient as a wanderer and had not provided him with an electronic security bracelet. He too was able to get out of the ward to a stairwell and rolled down the steps in his wheelchair. Clinical managers had not established safety measures to protect incompetent patients from wandering.

We made two recommendations. The Medical Center Director concurred with our recommendations and provided acceptable

implementation plans for one recommendation. The remaining recommendation is unimplemented pending receipt of further data. *(Inspection of Two Allegedly Serious Patient Falls, Central Alabama Veterans Health Care System, VAMC Tuskegee, AL, 9HI-A28-140, 7/30/99)*

Issue: Alleged substandard patient care and administrative discrepancies.
Conclusion: Employees are generally performing well under difficult circumstances.
Impact: Limited resources negatively impact on quality of care.

A complainant alleged there is waste, fraud, abuse, and mismanagement at the VA Outpatient Clinic, Chattanooga, TN. OHI inspectors made two site visits to review clinic operational policies, management structure and functions, and patient care delivery systems. Inspectors extensively interviewed the original complainant to clarify allegations and spoke with more than 100 patients and family members who sought to be interviewed.

We concluded that employees generally perform well under difficult circumstances, which are directly related to limited resources, a geographically remote parent facility, lack of readily available referral resources, and a medically challenging patient population. Compounding this difficult situation are issues of employee morale and interpersonal conflicts that impair the collaborative practice that must occur among professionals for them to manage such a complex patient population.

We made several recommendations. The Medical Center Director and the VISN Director concurred with our recommendations and provided acceptable implementation plans. *(Inspection of Alleged Substandard Patient Care and Administrative Discrepancies, Outpatient Clinic, Chattanooga, TN, 9HI-A28-141, 7/30/99)*

Issue: Alleged inappropriate heart surgery.
Conclusion: Emergency surgery was appropriate given the severity of the patient's coronary artery disease.
Impact: Informed consent needs strong and clear documentation in the medical record.

The wife of a patient alleged that her husband received substandard care while hospitalized, that he should have been evaluated for cardiac disease and hospitalized earlier, and questioned the validity of the patient's consent for a coronary artery bypass graft operation. The patient had a complicated post-operative course that ultimately resulted in his death.

We concluded that clinicians promptly diagnosed the patient's heart condition and that emergency surgery was appropriate, given the severity of the patient's coronary artery disease. We further concluded that clinicians properly obtained the patient's consent for surgery. We made one recommendation concerning the peer review process. The Medical Center Director concurred with our recommendation and provided an acceptable implementation plan. *(Inspection of Allegedly Inappropriate Open Heart Surgery, VAMC West Los Angeles, CA, 9HI-A28-151, 8/18/99)*

Issue: Inappropriate services for the visually impaired at VAMC Augusta.
Conclusion: Some patients have been inappropriately admitted to the Blind Rehabilitation Center.
Impact: Better admission screening leads to more effective results.

We received a complainant's letter concerning issues involving the appropriateness of admissions to the VAMC's inpatient Blind Rehabilitation Center and of the outpatient care and services provided in the Visually-Impaired Service's Low-Vision or Optometry clinics. In

both categories of allegations, there were cases involving allegedly unnecessary or inappropriately issued low-vision prosthetic items. We obtained assistance from three consultants who are considered experts in low vision optometry and blind rehabilitation.

We confirmed that some patients have been inappropriately admitted to the Blind Rehabilitation Center, and we also partially substantiated cases in which optometry and/or prosthetic services were inappropriate or less than optimal. We concluded that program and operating improvements of the Center, Visually-Impaired Service's team, and Optometry Services in the VAMC are needed.

We made seven recommendations that should improve the quality and appropriateness of care in the Blind Rehabilitation Center and the various Visually-Impaired Service's clinics, as well as the appropriateness of and need for prosthetic items issued to low-vision or blinded patients. The Medical Center Director provided acceptable implementation plans. *(Inspection of Allegedly Inappropriate Visually Impaired Service, VAMC Augusta, GA, 9HI-A28-159, 9/16/99)*

Issue: Missing patients.
Conclusion: Improvement is needed in the management and monitoring of high-risk patients.
Impact: Ability to ensure patient safety and improve health care.

We conducted an oversight inspection to evaluate the medical center's review of the circumstances surrounding a patient's disappearance and the actions taken to prevent similar incidents from reoccurring. The patient was attending a recreational activity with other patients and volunteers when, at the completion of the activity, he wandered away and did not return to his ward. He was reported missing and was found dead 3 days later. The patient had fallen into a 4-foot deep ditch that contained about 2 feet of water. The cause of death was reported as an accidental drowning.

We reviewed the patient's clinical course, as well as the supervision that medical center clinicians provided to the patient. Prior to our inspection, the Medical Center Director initiated a root-cause analysis to review the management of the patient's care and of the station's missing patient search procedures. We concluded that clinicians were aware of the patient's need for direction and supervision, but they failed to ensure that he was provided appropriate supervision during a recreational event. Managers appropriately ordered a review of the circumstances surrounding the patient's disappearance and subsequent death and have initiated corrective action to prevent a similar incident from reoccurring.

We made four recommendations that address the issues in this case. The Medical Center Director concurred with our recommendations and provided appropriate implementation plans. *(Inspection of the Management of a Missing Patient, VAMC Butler, PA, 9HI-A28-167, 9/21/99)*

OFFICE OF MANAGEMENT & ADMINISTRATION

Mission Statement

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

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

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

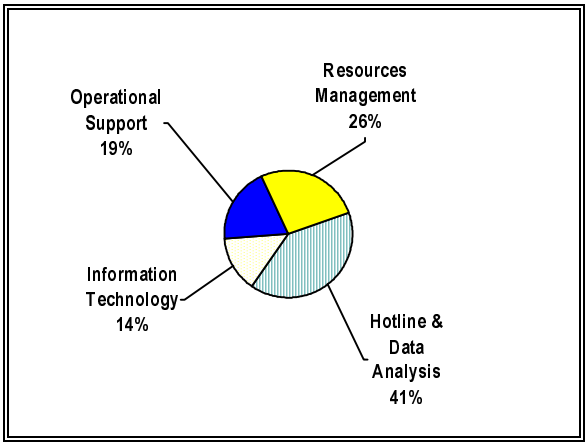
II. Operational Support Division - The Division does followup tracking of OIG report recommendations; Freedom of Information Act (FOIA) releases; strategic, operational, and performance planning; and IG reporting and policy development.

III. 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. The Division also maintains the Master Case Index (MCI) system, the OIG's primary information system for case management and decision making.

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

Resources

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



I. HOTLINE AND DATA ANALYSIS DIVISION

Mission Statement

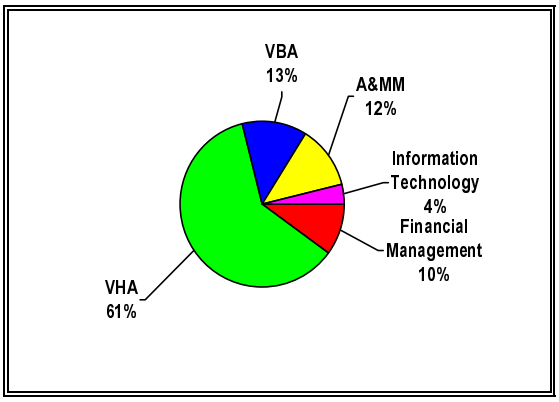
Ensures that allegations of fraud, waste, abuse, and mismanagement are responded to in an efficient and effective manner. Provides automated data processing technical support to all elements of the OIG and other Federal Government agencies needing information from VA files.

The Hotline Section operates a toll-free telephone service five days a week, Monday through Friday, from 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 8 employees in the Data Analysis section, which provides support to all OIG operating elements. The following chart shows the percent of resources utilized by various program areas.



Overall Performance

During the reporting period the Hotline received 7,289 contacts. Of this number, 396 cases were opened. The OIG reviewed 76 of these and the remaining 320 cases were referred to VA program offices for review.

Output

- During the reporting period, Hotline staff closed 358 cases, of which 105 contained substantiated allegations (29 percent). The Hotline staff opened 166 cases and generated 230 letters responding to inquiries received from members of the Senate and House of Representatives.

Outcome

- VA managers imposed 35 administrative sanctions against employees and took 55 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled $1,336,241. Data Analysis staff's participation in a joint effort with other OIG elements and VA officials resulted in the identification of $700,000 in checks cashed after the payee's death. Action was taken to stop the awards and initiate collection actions.

A. HOTLINE SECTION

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

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

Veterans Health Administration

Patient Care and Service

- A VAMC review prompted by a Hotline inquiry substantiated an allegation that an employee used improper techniques while handling a patient with fragile skin. Consequently, the patient received a laceration. The employee received several hours of training and a written counseling. The review also revealed the same employee was removed from a ward 6 years ago for physical abuse. At that time, the employee received a 14-day suspension and successfully completed a performance improvement plan. Since that suspension, no allegations of patient abuse have been reported against the employee up to this incident. Management is closely monitoring this situation.

- As the result of a Hotline inquiry sent to a VAM&ROC, a review found there no systems were in place to ensure patient safety and to expedite appointments and processing. Management implemented procedures to correct this oversight.

- A Hotline inquiry prompted a VAMC review, which substantiated allegations of employee misconduct and violation of patient safety by a triage nurse and police officer. The nurse was administratively counseled on her lack of interpersonal skills. The police officer was administratively counseled on his lack of customer service and was advised to seek the advice of a clinical provider on a patient's medical status before touching any patient. The director of the facility wrote a letter of apology to the veteran.

- A VAMC investigation disclosed an employee shut off electrical power to the surgical suite during a procedure. Although the patient was unharmed, the employee was suspended without pay for 60 days.

Employee Misconduct

- Another Hotline inquiry sent to a VISN prompted an investigation of alleged improprieties at a VAMC. The review resulted in a reprimand being issued to the chief, Fiscal Service, for improper use of his Government credit card. The investigation also found the chief had borrowed money from a subordinate employee. The chief retired when he received a proposed reprimand for his actions. Another Fiscal Service employee was issued a termination letter for time and leave abuse discovered during the investigation. An employee who refused to answer questions during the investigation received a three-day suspension.

- Another Hotline referral to a Readjustment Counseling Service prompted a review which substantiated allegations that four employees willfully misused Government vehicles. One employee also admitted having a Government computer at home without authorization. Management suspended the supervisor for 30 days for using the vehicle to routinely commute back and forth to work without authorization and for authorizing similar use by subordinate staff. Three employees received admonishments for unauthorized use of the vehicles. The employee who took the computer home also received a 14-day suspension for endangering client confidentiality.

- A VAMC review substantiated an allegation of misuse of a Government credit card. An employee used his card for personal purchases and travel, without submitting a travel request. The employee received a written counseling and additional training on travel regulations.

- A VAMC review confirmed the allegation that an employee had misused VA franking privileges. When approached by management, the employee admitted to making personal use of VA envelopes and agreed to reimburse the VA for whatever amount was necessary. Employee was issued a bill of collection for $300 and a written counseling.

- An investigation by a VAMC director substantiated the allegation of improper use of a Government credit card by a union official. The official used the card for personal purchases. The official was counseled and repaid the VAMC for $1,463 in unauthorized charges.

- A VAMC review substantiated allegations of employee misconduct, use of official position for personal gain, and minor misuse of a Government vehicle. The Facilities Management Service supervisor and one employee received reprimands. Management issued a notice to all VAMC employees reminding them of proper procedures.

Quality of Care

- A Hotline inquiry to another VISN prompted a review that substantiated an allegation of poor quality of care at a VAMC. A veteran was able to elope from a psychiatric ward as the result of a lack of supervision by his treatment team. VAMC management established better monitors and lines of communication between the team members and with the patients.

- A VAMC review substantiated an allegation of poor quality of care. A physician diagnosed a veteran's elbow condition based on a review of the medical records and not a physical examination. Management counseled the physician and acted to ensure that attending physicians examine patients personally.

- A VISN review prompted by a Hotline inquiry substantiated allegations of poor quality of care and mismanagement of resources by a VAMC. The VAMC failed to sufficiently anticipate a series of circumstances that led to insufficient radiology coverage and a backlog of unread radiological procedures. The VAMC corrected the situation.

- A VAMC review revealed poor quality of care in the treatment of a veteran at a VA outpatient clinic. The physician reviewed diagnostic test results but failed to examine the patient who had a head injury. The clinic also failed to provide timely follow-up care. The physician was counseled by the facility and system reviews have been revised to streamline scheduling processes between the outpatient clinic and the medical center.

- A review at a VAMC found that problems with timely hiring of nursing staff created difficulties in responding to nursing home

patients. Management took action to address the time required for responding to the needs of residents.

- An investigation by a VAMC director substantiated the allegation of improper surgical resident on-call scheduling, which resulted in residents working 120-hour weeks. The director took immediate action to reduce the number of hours the residents were expected to be on call. Additionally, the medical center implemented a monitoring system to ensure that proper rotation schedules are maintained.

Outside Employment

A Hotline inquiry initiated a VAMC investigation, which found the facility's dental laboratory supervisor performed lab work for a VA dentist's private practice using VA materials on VA time. The dentist admitted that the work was done and that he and the employee were friends. The service chief counseled the dentist on VA rules and regulations concerning outside work, the appearance of nepotism, and misuse of Government property.

Contracting Activity

- A VHA review found double billing by a contract pharmacy and the overpayment of veteran co-pay amounts. The pharmacy was paid twice for the same prescription in two instances, resulting in the veteran being inappropriately charged a co-pay amount. VHA recovered $191 from the contract pharmacy and refunded $63 to the veteran.

Government Equipment and Supplies

- A Hotline inquiry, and subsequent requests for a senior-level VHA review, determined that the proposed replacement of an essentially new telephone system at a VAMC was unnecessary. VHA held that the VAMC's PBX switch was incompatible with a VISN-wide telephone system being purchased from a single vendor. After receiving the Hotline inquiry, VHA reconsidered its position and decided the incremental costs associated with the replacement of the VAMC's existing system did not justify its replacement at this time. Based on this decision, VA avoided costs estimated at $1 million.

- A VAMC review found an employee had improperly used the e-mail system to solicit other employees to join a gambling pool at $25 per person for a weight loss contest. Management counseled the employee.

- A VAMC review substantiated the allegation that employees had used Government telephones to make personal calls during working hours. Three employees were counseled.

- A technical review at a VAMC found the facility used multiple non-standard approaches to deal with the telecommunications system. The VAMC implemented the recommended corrective actions, including the development of consistent procedures based on industry standards.

Timekeeping Procedures

- A Hotline inquiry to a VAMC director prompted a review that substantiated an allegation of time and attendance abuse. The investigation found two supervisory staff members did not follow appropriate procedures in reporting time and attendance. The supervisors were formally counseled on documenting time and absences and the importance of employees' perceptions.

- Another Hotline inquiry to a VAMC found that a supervisor used inefficient timekeeping methods. Additionally, it was discovered that an alternate timekeeper was inappropriately accessing timecards and violating privacy

information in discussing employees' time and attendance issues. Management counseled the supervisor and employee. The alternate timekeeper was relieved of her timekeeping duties and the VAMC implemented procedures to ensure that staffs maintain accurate timekeeping records in the future.

- A VAMC review substantiated the allegation that two nurses had inappropriately received pay for unnecessary on-call duty. One employee received on-call pay for 9 years. Management stopped the on-call tour of duty for both employees and issued bills of collection to recoup $8,971.

Beneficiary Travel Reimbursement

A Hotline inquiry to a VAMC found that a veteran claimed he was residing in another city to obtain higher beneficiary travel reimbursements; however, the review found he lived close to the VAMC. Consequently, the VAMC billed the veteran for $2,414. The VAMC also recorded the veteran's current address and reduced his travel reimbursement.

Veterans Benefits Administration

Benefits Payments to Incarcerated Veterans

- As the result of a Hotline inquiry to one VARO, staff took action to review and confirm that a veteran was incarcerated and inappropriately receiving VA benefits. The VARO reduced the veteran's benefits and created an overpayment of $76,917.

- Another Hotline inquiry prompted a review by VARO staff, which substantiated the allegation that a veteran continued to receive 100 percent compensation while incarcerated in South Carolina. The veteran was incarcerated in November 1998 and failed to notify VA. VARO staff assessed an overpayment of more than $9,900.

- A Hotline inquiry found that a veteran was receiving full compensation benefits while incarcerated. The veteran failed to notify the VARO of his incarceration, which began in June 1998. The veteran was assessed an overpayment of more than $2,300.

- A VAMC review discovered an incarcerated veteran had assumed the identity of another veteran and received VAMC social work services under the assumed identity, which resulted in the veteran being billed for services. The VAMC cancelled the charges and flagged the veteran's information in their computer system to prevent future fraudulent receipt of medical services. The VAMC also notified the VARO of the veteran's incarceration, which resulted in the creation of a $25,000 overpayment.

Receipt of VA Benefits

- As the result of a Hotline inquiry sent to one VARO, action was taken to review the appropriateness of a veteran's 100 percent service connected rating for blindness. The VARO staff determined the rating was inappropriate because the veteran was shown on videotape driving an automobile. The veteran's rating was reduced to 50 percent, his individual unemployability benefit terminated, and his special benefits for total blindness were discontinued. The VARO's actions resulted in savings of approximately $27,600 that would have otherwise continued to be paid to the veteran over the VA budget cycle.

- A VARO field examination determined that a veteran's receipt of disability compensation at a 100 percent level based on individual

unemployability was unwarranted. The VARO found the veteran, who was supposedly wheelchair-bound, could walk and worked on and raced motorcycles. The VARO reduced the veteran's compensation to 40 percent, and his monthly benefit payment from $1,924 to $399. The VARO's actions will save the Government from having to unnecessarily pay $18,300 over a one-year period.

- A Hotline-prompted inquiry found a veteran received VA benefits during periods he was on active duty and receiving service pay. This resulted in an overpayment of $8,204.

- A VARO field exam substantiated an allegation that a veteran was receiving pension benefits for which he was not entitled. The pensioner was found to have a non-reported monthly income of $3,000 from self-employment. The VARO created an overpayment of $48,594.

- A VARO review substantiated an inappropriate increase of a veteran's pension based on medical expenses. At the time the increase was approved, the veteran was a patient at a state veterans nursing home and his medical expenses were already covered. The VARO notified the veteran his pension would be reduced, creating an overpayment of $19,221.

- A VARO review revealed that a veteran's widow receiving DIC benefits had remarried twice and not reported her change in marital status to VA. The widow was assessed an overpayment of $95,320 for the benefits she received over a ten-year period.

- A VARO review resulted in confirmation that a veteran's widow had continued to receive DIC for six years after her remarriage. The VARO cancelled the widow's benefits and recouped $23,486.

VA Loan Guaranty Program

A Hotline inquiry prompted a review which found a veteran was using a $240 monthly mortgage payment allotment from his military retirement pay to avoid an IRS tax lien. The veteran's mortgage loan was paid off in 1996 but the veteran had made no attempt to stop the allotment until contacted by the VA regional office and insurance center. The center refunded the veteran his accumulated funds and notified IRS of this action.

National Cemetery Administration

A NCA review substantiated the grave of a veteran who died in 1976 did not have a headstone. NCA contacted the cemetery and found that the headstone had been delivered years earlier, but the family was never notified that they had to pay for the concrete foundation and granite base. The family has been notified and is making payment to the cemetery.

Office of Human Resources and Administration

A VA Office of Resolution Management review at a VAMC confirmed that an Equal Employment Office counselor shredded documentation submitted as part of an complaint. The review concluded the counselor erred in deciding to shred excess documentation that was not pertinent to the case. The employee was counseled. Management apologized to the complainant.

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.

During the semiannual period, the section completed work on 295 requests for information received from OIG operational elements. 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 the staff is shown in many of the projects and investigative cases described in this report.

The section worked on 18 other projects to develop computer profiles, which would identify fraud and abuse in VA systems. Some of these profiles are currently in use by investigative and audit staff at several OIG regional offices.

The section also completed work on 81 requests received from contract review auditors, which generated 214 outputs. Support was provided on 13 other specific projects consisting of 116 vendor sales containing more than 55 million records. The monetary results of these efforts are reported in the Office of Audit section of this semiannual report under results of postaward and preaward contract reviews.

In addition, the staff completed work on 57 other requests for information received from VA management and other Federal agencies. The section routinely receives requests from the FBI, HHS, Air Force Office of Special Investigations, and other DoD organizations. The following reflects some of the data collected and analyzed for these groups.

Computer Profiles Developed Detected Fraud and were Successful in Stopping Inappropriate Benefit Payments

Working with the OIG Office of Investigations and the VA Financial and Systems Quality Assurance Service, the Data Analysis staff developed and tested computer profiles designed to search for data patterns that pointed to the potential for fraud in the system. Tests conducted at five VAROs resulted in the identification of 29 inappropriate benefit claims. The VARO staffs established overpayments and OIG investigative work continues. The reviews identified approximately $700,000 in improper payments. The computer profiles have been refined and used in detecting fraud patterns in other VAROs.

Reviews of Computer Systems Identified Problems Warranting Attention

- During a review of fee basis master files programmed by the VA Austin Automation Center, the Data Analysis staff found a Y2K problem. The Center corrected the problem and notified their customers of the error.

- While working with VBA loan guaranty production programs, the section identified several coding errors that caused inaccurate output reports. VBA agreed to correct the production programs and test them to make sure their figures were accurate.

- During a review of accounts receivable files received quarterly from all VA stations nationwide, the staff identified duplicate billings. The records were sent to an individual station for resolution. Staff found the duplicate

billings were caused by a computer system failure at the station in 1993. Action was taken to correct the problem.

- While working with VBA's first notice of death records, the section found an anomaly where the system failed to recognize a command to stop payment on a claim. Consequently, payments continued to be sent out to an address for a period of 17 months with the checks issued totaling about $47,500. Fortunately, the post office returned the check each month as undeliverable. As the result of the review, VBA staffs are looking into this matter to ensure it does not happen with other payments. VBA is also looking into procedural changes in the handling of notices to stop payments nationwide.

- While reviewing VA files to determine if any VA entity was doing business with a company that had been excluded from participation in Medicare, Medicaid, and other Federal health care programs, the staff identified eight VAMCs that made purchases totaling about $75,000 from at least seven companies on an exclusion listing. The information was sent to A&MM for action as warranted.

Requests from VA for Data Support

- During this reporting period, the VBA Data Management office requested assistance in providing them with computer files developed for the audit of VA's Consolidated Financial Statements. VBA staff found these reports a useful management tool and will be running these files on a recurring basis as part of their production processing requirements. The section provided them with all specifications, report formats, record layouts, and computer coding Data Analysis developed for use in determining the actuarial calculation of future liabilities of veteran's benefits.

- VHA also requested the staff's assistance in providing them with computer programs the section had developed for the Medical Care Cost Fund portion of the Consolidated Financial Statements audit. Office of Audit found the reports very helpful in reconciling major differences they were experiencing in their accounts receivable files. VHA is now running these programs in a production environment on a routine basis.

Support Provided to Contract Review and Evaluation Efforts

- During this 6-month period the section also provided ADP technical support to the Office of Audit's Contract Review and Evaluation Division which conducts preaward and postaward reviews of certain categories of VA contracts. Some examples of the work the Data Analysis staff performed follow.

- One postaward review revealed that a certain pharmaceutical company had converted from one computer system to another in the middle of the contract and in the process the prices it charged for certain items had been lost or were posted incorrectly. Using sales files the section had received from the company on a previous request, the staff members were able to go back several years and reconstruct the price changes on the new sales file forward so that the audit work could continue.

- During one other review, the section developed a multi-step programming procedure that allowed the staff to compute price reductions for 125 items that would have been virtually impossible without the procedure. There were two price reduction clauses in the contract that calculated price reductions the VA was entitled to during four different periods during the contract. The Data Analysis staff identified approximately 60,000 sales to VA that were entitled to the price reductions and recalculated the amounts in support of the review.

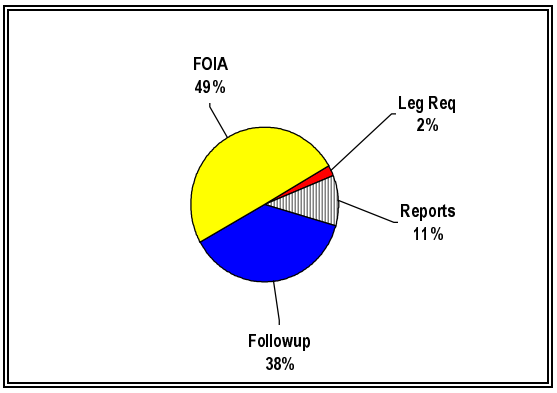
II. OPERATIONAL SUPPORT DIVISION

Mission Statement

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

Resources

This Division has 8 FTE with the following allocation:



Overall Performance

Followup on OIG Reports

The Division is responsible for obtaining implementation actions on audits, inspections, and reviews with over $1 billion of actual or potential monetary benefits as of September 30, 1999. Of this amount $909 million is resolved, but not yet realized as VA has agreed to implement the recommendations, but is not yet finished. In addition, $114 million relates to unresolved reviews awaiting contract resolution by VA contracting officers.

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

Management officials are required to provide the OIG with documentation showing the completion of corrective actions, including reporting of collection actions until the amounts 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 September 30, 1999, VA had 108 open internal OIG reports with 298 resolved but unimplemented recommendations and 43 unresolved contract review recommendations which are awaiting contracting officer's decisions.

After obtaining information that showed management officials had fully implemented corrective actions, the Division took action to close 67 internal reports and 230 recommendations with a monetary benefit of $464 million.

During this period, 100 percent of followup requests on immediate actions were sent within three months. Also, 100 percent of the initial

and the subsequent followup letters were processed in less than 3 months. In both cases, we met the standard.

FOIA, Privacy Act, and Other Disclosure Activities

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

During this reporting period, we processed 220 requests under the Freedom of Information and Privacy Acts and released 259 audit, investigative, and other OIG reports. In one instance we had no records. We totally denied four requests under the appropriate exemptions of the Acts. Information was partially withheld in 156 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, 12 FOIA cases did not receive written responses within 20 working days, as required. Eleven complex cases were over 1 year old; seven of these were from the same requester. The average processing time for workable FOIA requests considered complex was 83 working days; while routine cases took 11 working days.

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

Review and Impact of Legislation and Regulations

The Division coordinated concurrences on legislative and regulatory proposals from the Congress, 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, 86 legislative, 30 regulatory, and 48 administrative proposals were reviewed and commented on, as appropriate.

III. INFORMATION TECHNOLOGY DIVISION

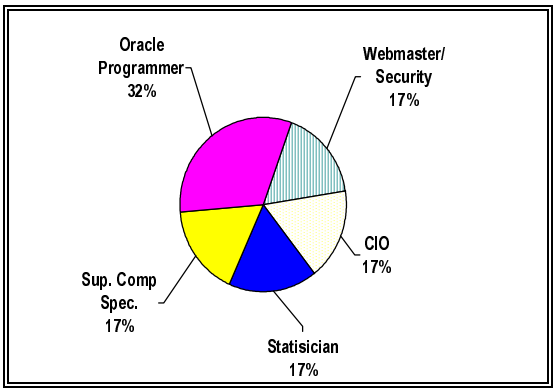
Mission Statement

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

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

Resources

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



Overall Performance

Master Case Index (MCI)

We completed the initial implementation of an Oracle database application known as MCI to replace a non-Y2K compliant 9-year old legacy Oracle application. This implementation culminated a 10-month conversion of 18 forms and 250 reports in the legacy application, as well as the creation of 20 additional forms, a new case numbering format, search tools, and an index to external reports of interest to the OIG. The graphical user interface of MCI provides users with intuitive access to their data denied them in the legacy application, which required experienced programmers to conduct on-line queries. Additionally, users now have appropriate access to enterprise-wide data instead of only data pertaining to their operational directorate. Within the next 6 months, we intend to expand the user base from approximately 40 in the legacy application to all OIG employees. Data validation tables, picklists, and search tools will result in increased

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

Internet Technology/Security

The Division is responsible for processing and controlling electronic publication of OIG reports, including maintaining the OIG websites and posting OIG reports on the Internet. We posted frequently requested CAP, administrative investigation, audit, and healthcare inspection reports in our electronic reading room in compliance with the Electronic Freedom of Information Act. We published more than 20 additional audit reports, 40 Office of Investigations press releases, and other OIG publications online. We added privacy statements and made our website more accessible for the visually impaired in accordance with Department of Justice guidance.

In collaboration with the Offices of Audit and Investigations within the OIG, we placed Workers' Compensation Program case management and fraud detection resources online for VA managers. We published the Office of Audit internal peer review guide for the Federal audit community for use in checking conformance with Government auditing standards.

At the request of Congressional staff, we created an electronic copy of a CAP report on the North Florida and South Georgia Veterans Health System. We provided technical advice to OIG FOIA staff on sensitive computer or systems information that should be withheld from OIG reports in order to protect system integrity.

We participated in departmental efforts in improving information security including recent budgetary, resources, and policy initiatives, including the Department's participation in the Government electronic white pages project and departmental efforts to improve how the VA uses the Internet to serve its customers.

Statistical Support

The OIG statistician, part of the technical support team under the direction of the OIG's Chief Information Officer, provides statistical consultation and support to the OIG. Statistical consultation involves providing assistance and direction in the planning, designing, and sampling for relevant IG projects. Statistical support includes providing assistance in the implementation of a project's methodology to ensure that data collection, preparation, analysis, and reporting are accurate and valid.

During this period, the OIG statistician provided statistical consultation and support on 11 sampling plans for proposed audit projects, 3 OHI proactive program evaluations, and 4 CAP reviews. In addition, the statistician provided statistical consultation on appropriate data and methods that could be used in support of two pending OHI evaluations for the upcoming fiscal year. Much of the proactive statistical analysis of data was associated with VHA’s policies and procedures for discharge planning of long-term, nursing home patients, the treatment of veterans with hepatitis C, the quality of care provided at selected VAMCs, and establishing appropriate methods for assessing similarities and difference in quality across centers.

IV. RESOURCES MANAGEMENT DIVISION

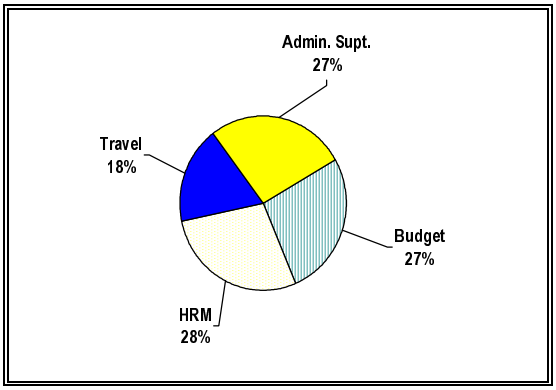
Mission Statement

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

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

Resources

The Division has 11 FTE currently assigned to the OIG headquarters. The staff allocation for the five functional areas is as follows:



Overall Performance

Budget

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

The staff executed 99.83 percent of the OIG's FY 1999 budget authority.

Human Resources Management

During this period, the staff wrapped up the FY 1999 recruitment and hiring campaign, bringing on board 40 new employees. In addition, the staff processed 175 personnel actions, 12 IG awards, 40 AIG awards, 5 distinguished career awards, 2 outstanding career awards, 254 special contribution awards, 8 time-off awards, 7 quality step increases, and 4 on-the-spot awards.

Travel

OIG personnel travel almost continuously. As a result, the Travel section processed 1,632 travel and 32 permanent change of station vouchers in addition to 17 new permanent change of station authorities and 27 amendments to existing authorities.

Administrative Support

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

In addition, this component processed 290 procurement actions and reviewed and approved each month the 42 statements received from the OIG's cardholders under the Government's purchase card program.

OTHER SIGNIFICANT OIG ACTIVITIES

President's Council on Integrity and Efficiency (PCIE)

Federal Audit Executive Council

The Assistant Inspector General (AIG) for Auditing serves on the Board of Directors of the Federal Audit Executive Council. The purpose of the Council 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.

PCIE Awards

On September 29, 1999, a number of OIG employees received recognition at the 2nd Annual PCIE/Executive Council on Integrity and Efficiency Awards Program. This year's program was particularly gratifying as our organization was recognized in several different IG categories.

Career Achievement Award

Michael J. Costello, our recently retired AIG for Investigations, received recognition of his outstanding leadership and many contributions to Federal law enforcement. His accomplishments have resulted in fines, penalties, restitutions, recoveries and other monetary benefits valued at over $300 million.

Award for Excellence – Financial Statement Audit Network Group

John Jonson, Director, Financial Management Audit Division, was recognized for identifying and resolving key issues related to the preparation and audit of Federal financial statements.

Award for Excellence

Pat Christ, Director, Health Systems Development Division, and a Registered Nurse, was recognized for her outstanding leadership and efforts on enhancing and strengthening the image and reputation of the OIG as a professional, impartial, and dynamic organization.

Award for Excellence

The following OIG staff were recognized for the assignment addressing VA's Worker's Compensation Program.

- **The Office of Audit, Central Office Operations Division** -- Stephen Gaskell, Director; James Farmer, audit manager; Sandra Miller, lead auditor; and Melvin Reid, staff auditor.

- **The Office of Management and Administration, Hotline and Data Analysis Division** -- Roger Perez, Director; Emil L. Balusek, supervisory computer specialist; and Trudy Pickle, computer specialist.

- **The Office of Investigations, Central Office, Northeast Field Office, and Western Field Office** -- James Gaughran, Program Director, benefits fraud; Bruce Sackman, Special Agent in Charge (SAC), Northeast Field Office; John McDermott, Assistant SAC, Northeast Field Office; Claire Chico, special agent; Thomas Hill, SAC, Western Field Office; John Hambrick, Assistant SAC, Western Field Office; and Wayne Nomi, special agent.

Honorable Mention

- **Atlanta Audit Operations Division** -- James Hudson, Floyd Dembo, George Patton, Marcia Drawdy, Scott Harris, Harvey Hittner,

Thomas Holloway, John Richardson, Leon Roberts, Mu Taalib, Cheri Preston, Emil Balusek, Trudy Pickle, and John Hisnanick (OIG statistician) were given honorable mention for conducting an evaluation of VBA benefit payments to incarcerated veterans to determine whether recommendations made a 1986 OIG report were implemented.

- **Laney College Investigations Team** -- Michel Seitler, Alan Dal Porto, Patrick McCormack, Dean Wauson, and Paul Lore, all special agents in the Western Field Office, were given honorable mention for their combined investigative efforts which led to criminal convictions of two individuals involved, and collateral civil proceedings involving over 200 individuals, in the largest education benefits fraud scheme ever perpetuated against VA.

OIG Management Presentations

VA Information Technology Conference

The following OIG audit officials made presentations at the Conference, which is VA's premier conference on the innovative use of information technology to improve VA operations.

- The Director, Central Office Audit Operations Division; project manager of the audit of workers' compensation; and the Special Agent in Charge, Northeast Field Office of Investigations, gave a presentation on detecting fraud and reducing workers' compensation costs. Workers' compensation officials from VISNs in Albany, NY and Long Beach, CA also participated in the panel discussion.

- Managers from the Central Office Audit Operations Division and the Financial Management Audit Division gave a presentation on audit issues identified concerning VA information security.

- Managers from the Seattle Audit Operations Division gave a presentation on the use of automated information to improve medical center supply inventory management.

- The Directors of the Atlanta and Seattle Audit Operations Divisions gave presentations on the OIG's Combined Assessment Program.

Washington, D.C. Law Firm Presentation

At the request of a Washington, D.C. law firm, the OIG Counselor and Director, Contract Review and Evaluation Division, gave a presentation on the process used by the OIG to address voluntary disclosures made by companies concerning internal reviews that identify contract overcharges.

United States Surgical Corporation Presentation

The Director, and an audit manager in the Contract Review and Evaluation Division, gave a presentation on the OIG role in VA's Federal Supply Schedule contracting program. Presentation topics included preaward and postaward reviews, commercial selling practices, and the effect of the GSA's August 1997 final rule on the Federal Supply Schedule program. The presentation was videotaped for incorporation into their on-going training program.

First Annual Federal Workers' Compensation Conference and Exposition

The Director, Central Office Audit Operations Division, and the Special Agent in Charge, Northeast Field Office of Investigations, gave a presentation on detecting fraud and reducing workers' compensation costs. An official from the Austin Automation Center also participated in the presentation by providing a demonstration on the use of VA's Workers' Compensation

Management Information System. The conference was a collaborative effort between VA and several Federal agencies and provided educational opportunities for managing claims under the Federal Employees' Compensation Act.

VHA Information Security Conference

VA OIG audit staff made a presentation on the results of our review of VHA ADP security conducted as part of the FY 1998 Consolidated Financial Statements audit.

Association of Government Accountants Conference

The Director, Financial Management Audit Division, gave a presentation on using financial analysis to develop operational audits at the Los Angeles professional development conference.

Presentation to Leadership VA Alumni Association

The Inspector General made a presentation on the work of the OIG to the Leadership VA Alumni Association Forum. This conference is organized by graduates of VA's premier leadership development program.

OIG Congressional Testimony

In April 1999, the Deputy Assistant Inspector General for Auditing and the Director and project manager in the Central Office Audit Operations Division testified before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations. The testimony highlighted the OIG's review and oversight of VA's efforts to address Y2K issues and become Y2K compliant.

In September 1999, the Inspector General, accompanied by the Assistant Inspector General Auditing and the OIG Counselor, testified before the House Committee on Veterans Affairs, Subcommittee on Oversight and Investigations. The testimony addressed the OIG's views on fraud and mismanagement in veterans benefits, debt management, and procurement and contracting activities and summaries of the OIG audits and investigations in those areas.

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, 16 subpoenas were issued in conjunction with various OIG investigations and audits.

APPENDIX A

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM				
9IGCAP502 4/22/99	Combined Assessment Program Review North Florida and South Georgia Veterans Health System			
9IGCAP503 6/30/99	Combined Assessment Program Review of the Southern Nevada Veterans Healthcare System			
9IGCAP504 9/24/99	Combined Assessment Program Review Louis Stokes Cleveland VA Medical Center, Cleveland, OH			
INTERNAL AUDITS				
9R1F05088 5/3/99	Audit of Department of Veterans Affairs Medical and Regional Office Togus, ME			
9D2G07049 6/10/99	Audit of VA's Year 2000 Implementation Effort	$1,521,000	$1,521,000	
9R5D02118 6/14/99	Audit of Department of Veterans Affairs Minor Construction and Nonrecurring Maintenance Programs	$22,470,821	* $14,000,000	
9ANG10117 6/22/99	Report of Department of Veterans Affairs Enterprise Centers Financial Statement Audit for the Fiscal Year Ended September 30, 1998			
9R4A19124 6/28/99	Audit of Veterans Health Administration Emergency Medical Strategic Healthcare Group	$4,575,000	$4,575,000	
OTHER OFFICE OF AUDIT REVIEWS				
9D2G01002 4/14/99	Protocol Package for Veterans Integrated Service Network (VISN) Workers' Compensation Program (WCP) Case Management and Fraud Detection			
9D2G01064 4/14/99	Handbook for VA Facility Worker's Compensation Program (WCP) Case Management and Fraud Detection			

* Management disagreed with OIG estimate.

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
OTHER OFFICE OF AUDIT REVIEWS (Cont'd)				
9AFG10086 4/15/99	Management Letter: Expenditure Transactions			
9AFG10087 4/22/99	Management Letter: ADP Security at Philadelphia Regional Office and Insurance Center and Benefits Delivery Center			
9R1G01089 4/30/99	Management Advisory: Selected Financial Operations and Evaluation of Internal Controls, VA Boston Healthcare System			
9R1G01090 4/30/99	Management Advisory: Selected Financial Operations and Evaluation of Internal Controls, VA Pittsburgh Healthcare System			
9AFG10098 5/6/99	Management Letter: ADP Security at Hines Benefits Delivery Center			
9R5B10099 5/6/99	Underwriting Practices Carolina Mortgage Company of Fayetteville, NC			
9R5B04103 5/12/99	Accuracy of Data Used to Measure Percent of Veterans With a VA Burial Option			
9AFG10097 5/13/99	Management Letter: ADP Security at Veterans Health Administration			
9R1G10100 5/21/99	Management Letter: Fiscal Year 1998 Financial Statements, VA Life Insurance Programs and Selected Loan Guaranty Program Financial Activities			
9AFG10106 6/1/99	Management Letter: ADP Security at Veterans Benefits Administration			
9R4G10116 6/14/99	Management Letter: Fiscal Year 1998 Consolidated Financial Statement Audit – Benefit Programs			
9R8A03113 6/18/99	Evaluation of Veterans Health Administration Management of Employee Quarters at VA Medical Centers	$39,794,000	* $38,832,000	
9R5B10123 6/23/99	Underwriting Practices, Southtrust Mortgage Corporation Birmingham, AL			
9R1B18127 6/30/99	Evaluation of Veterans Benefits Administration's Implementation of Customer Service Standards			

* Management disagreed with OIG estimate.

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
OTHER OFFICE OF AUDIT REVIEWS (Cont'd)				
9R4A02133 7/23/99	Evaluation of Veterans Health Administration Radiology and Nuclear Medicine Activities	$114,000,000	$114,000,000	
9D2A19121 8/12/99	Review of Hotline Complaints Concerning Issues Raised by Clinical Staff Questioning the Effectiveness of the Leadership and Management of the West Palm Beach VA Medical Center			
9R4A01146 8/16/99	Report of Evaluation, William S. Middleton Memorial Veterans Hospital Madison, WI			
9R5A19161 9/20/99	Accuracy of Data Used to Count the Number of Unique Patients			
9D2A19157 9/21/99	Survey Results - Audit of the Management and Operations of the Florida/Puerto Rico Veterans Integrated Service Network			
9R8E04164 9/23/99	Evaluation of Allegations Concerning Supply Management Practices at the Blind Rehabilitation Center, VA Medical Center Augusta, GA	$75,000	$75,000	
CONTRACT REVIEWS *				
9PEX20080 4/5/99	Survey of Allergan Incorporated's Public Law 102-585, Section 603, Policy and Procedures			
9PEX20085 4/9/99	Review of Nycomed, Inc.'s (Nycomed) Voluntary Disclosure Under Federal Supply Schedule Contract V797P-5982n			$46,716
9PEX06081 4/16/99	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97) Submitted by Pelton & Crane, Inc., Charlotte, NC			
9PEX04095 5/5/99	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q4-97) Konica Medical Corporation, Wayne, NJ	$138,087		
9PEX20071 5/6/99	Report of Survey – Serono Laboratories Inc.'s (Serono) Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585			

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
9PEX20101 5/10/99	Survey of Fujisawa Healthcare, Inc., Public Law 102-585, Section 603, Policies and Procedures			
9PEX25096 5/13/99	Final Report, Audit of Termination for Convenience Claim Submitted By Abt Associates, Inc., Contract Number V01(93)P-1446, Bethesda, MD			
9PEX10102 5/14/99	Review of Sannipoli Corporation dba Whited Cemetery Service's Offer to Provide Single and Double-Depth Graveliners Under IFB 786-5-99, Romoland, CA	$118,840		
9PEX20105 5/17/99	Survey of Forest Laboratories, Inc.'s Public Law 102-585, Section 603 Policies and Procedures			$69,448
9PEX20093 5/18/99	Review of Immunex Corporation's Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Numbers V797P-5307n and V797P-5280x			$32,825
9PEX20111 5/19/99	Review of UDL Laboratories Inc.'s Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585, Under Federal Supply Schedule Contract Number V797P-5335x			
9PEX20094 6/15/99	Survey of Upsher-Smith Laboratories, Inc.'s Public Law 102-585, Section 603 Policies and Procedures			$12,356
9PEX09122 6/17/99	Settlement Agreement Related to Overcharges on a Medical Equipment Contract			$1,252,869
9PEX20125 6/25/99	Report of Survey – Roberts Pharmaceutical Corporation Implementation of Section 603 Drug Pricing of Public Law 102-585			
9PEX20126 6/29/99	Survey of Boehringer Ingelheim Pharmaceuticals, Inc.'s Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Number V797P-5100n			
9PEX19070 7/8/99	Review of Federal Supply Schedule (Contract Number V797P-6566a) Tosoh Medics, Inc., South San Francisco, CA			$8,457
9PEX20131 7/9/99	Fujisawa Healthcare (USA), Inc., Reimbursement for Miscalculation of N-FAMP Data			$178

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
9PEX20058 7/20/99	Report of Survey – Solvay Pharmaceuticals Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585			
9PEX11136 7/21/99	Postaward Review of Federal Supply Schedule Contract V797P-5512m, Awarded to 3M Pharmaceuticals			$7,869
9PEX01139 8/6/99	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Baxter Healthcare Corporation – Hyland Division, Deerfield, IL	$1,127,908		
9PEX05150 8/18/99	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q2B-98) Johnson & Johnson Health Care System on Behalf of Ethicon, Inc. and Ethicon Endo-Surgery, Inc., Piscataway, NJ	$9,124,049		
9PEX05135 8/20/99	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q2B-98) Phoenix Medical Technology, Inc., Andrews, SC	$107,534		
9PEX12083 8/20/99	Postaward Survey of Boehringer Mannheim Patient Care Systems, Federal Supply Schedule Contract V797P-5261n			
9PEX20148 8/20/99	Review of Voluntary Disclosures on Federal Supply Schedule Contracts V797P-5728m, V797P-5554m and V797P-5354x Submitted By Novartis Pharmaceutical Corporation			$127,527
9PEX20152 8/23/99	Survey of G.D. Searle & Co.'s Public Law 102-585 Section 603 Policies and Procedures			
9PEX20153 8/25/99	Review of Novo Nordisk Pharmaceuticals Inc.'s Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585, Under Federal Supply Schedule Contract Numbers V797P-5057n and V797P-5224x			
9PEX11155 9/9/99	Review of Voluntary Disclosure and Refund Offer Submitted by Paddock Laboratories, Inc., Contract Number V797P-5162x			$15,105
9PEX20156 9/9/99	Review of a Voluntary Disclosure of a Public Law 102-585, Section 603 Computation Error and Refund Offer Submitted by Amgen, Inc., Contract Number V797P-5190x			$1,245

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
9PEX20134 9/14/99	Survey of Copley Pharmaceutical Inc., Public Law 102-585, Section 603, Policies and Procedures			$455
9PEX05158 9/17/99	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q2B-98) Kimberly-Clark Corporation Roswell, GA	$675,356		
9PEX20160 9/21/99	Report of Survey – Bracco Diagnostics Inc. Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585			
9PEX19165 9/22/99	Postaward Review of Food Services Prime Vendor Program (Contract Number 10-193P-1540) PVA/Monarch Food Services, Greenville, SC			
9PEX16171 9/23/99	Postaward Review – Voluntary Disclosure on Federal Supply Schedule Contract V797P-3378k, by Crown Therapeutics, Inc.			$399
9PEX18172 9/23/99	Postaward Review of Federal Supply Schedule Contract V797P-3602j, IVAC Corporation, San Diego, CA			
9PEX18173 9/23/99	Postaward Review of Federal Supply Schedule Contract V797P-3793j, Karl Storz Endoscopy-America			
9PEX18175 9/23/99	Postaward Review of Federal Supply Schedule Contract V797P-3983j, Zimmer, Inc.			
9PEX19166 9/23/99	Postaward Review of Food Services Prime Vendor Program (Contract Number 10-193P-1539) Avalon Distributing, Inc., Canal Fulton, OH			$42,663
9PEX20162 9/23/99	Survey Report - The Liposome Company, Inc.'s Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585, Federal Supply Schedule Contracts V797P-5938n and V797P-5131x			
9PEX20163 9/23/99	Survey Report - Medeva Pharmaceuticals, Inc.'s Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585, Federal Supply Schedule Contracts V797P-5536m, V797P-5197x, and V797P-5577m			
9PEX20168 9/23/99	Report of Survey – Ferndale Laboratories, Inc. Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
9PEX20170 9/23/99	Survey of ICN Pharmaceutical's Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585, Under Federal Supply Schedule Contract V797P-5658m			
9PEX20174 9/23/99	Report of Survey – Centeon LLC's Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585			
9PEX18176 9/24/99	After Contract Rebate Settlement Agreement, Federal Supply Schedule Contract V797P-3622j, Angelica Image Apparel, St. Louis, MO			$108,952
ADMINISTRATIVE INVESTIGATIONS				
9PRE11057 4/15/99	Administrative Investigation, Justification for the Lease of Non-Standard Passenger Vehicles by the Veterans Health Administration, VA Central Office			
9PRA01110 6/4/99	Review of the Reliability of an Administrative Board of Investigation Concerning a Patient Search and Recovery, VA New Jersey Health Care System, Lyons Campus			
9PRA99060 6/22/99	Administrative Investigation, Time and Attendance Issues, VAMC Salisbury, NC			
9PRE11114 6/22/99	Administrative Investigation, Procurement and Use of a Government Vehicle and Other Issues, Veterans Integrated Service Network, Boston, MA			$4,992
9PRQ02144 8/3/99	Administrative Investigation, Voluntary Leave Transfer Program Administration Issues, VA Central Office			
9IQA99142 8/5/99	Administrative Investigation, Use of Vehicles and Telephones By Union Officials, and Reprisal Issues, VA Ambulatory Care Center, Las Vegas, NV			
9IQE99132 8/11/99	Administrative Investigation, Use of Local Supply Funds for Travel by Various Acquisition and Materiel Management Service Chiefs, VA Central Office, Washington, DC			
9PRE03143 9/15/99	Administrative Investigation, Contracting Issues at the VA Chicago Health Care System, Chicago, IL			

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

ADMINISTRATIVE INVESTIGATIONS (Cont'd)

9IQE06154 9/16/99	Administrative Investigation, Use of a Government Vehicle for an Unofficial Purpose, Ralph H. Johnson VA Medical Center, Charleston, SC			
9DQG02169 9/23/99	Administrative Investigation, Privacy Act Issue, Office of Human Resources Management, VA Central Office			

HEALTHCARE INSPECTIONS

9HIA28084 4/8/99	Preliminary Assessment of the Veteran Health Administration's Missing Patient Search Procedures			
9HIA28091 4/28/99	Inspection of Alleged Poor Quality of Care of Three Nursing Home Care Patients, Department of Veterans Affairs Central Alabama Veterans Health Care System, East Campus, Tuskegee, AL			
9HIA28092 4/28/99	Inspection of Alleged Inadequate Treatment for Aortic Stenosis, Department of Veterans Affairs Medical Center Denver, CO			
9HIA28104 5/13/99	Inspection of Alleged Undetected Nursing Home Patient's Death, and Alleged Elopement and Subsequent Death of a Psychiatric Patient, Department of Veterans Affairs Medical Center Northport, NY			
9HIF03107 5/13/99	Quality Program Assistance Review, Department of Veterans Affairs Medical Center, Baltimore, MD			
9HIA28108 5/17/99	Inspection of Alleged Denial of a Patient's Rights Department of Veterans Affairs Medical Center Northport, NY			
9HIA28109 5/17/99	Inspection of Alleged Poor Quality of Care in the Dialysis Unit, John J. Cochran Division of the Department of Veterans Affairs Medical Center, Saint Louis, MO			
9HIA28112 5/26/99	Inspection of Multiple Allegations of Pharmacy Service Mismanagement and Substandard Patient Care, VA San Diego Healthcare System, San Diego, CA			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
HEALTHCARE INSPECTIONS (Cont'd)				
9HIA28128 6/29/99	Inspection of Alleged Substandard Care and Unprofessional Treatment VA Gulf Coast Veterans Health Care System Biloxi, MS			
9HIA28129 6/29/99	Inspection of Alleged Patient Abuse VA Gulf Coast Veterans Health Care System Biloxi, MS			
9HIA28130 6/29/99	Inspection of Alleged Ventnor, New Jersey Outpatient Clinic Inefficiencies Department of Veterans Affairs Medical and Regional Office Center Wilmington, DE			
9HIA28119 6/30/99	Oversight Review of Selected Aspects of the Veterans Health Administration's Traumatic Brain Injury Program			
9HIA28137 7/30/99	Inspection of Alleged Poor Quality of Care, William S. Middleton Memorial Veterans Hospital, Madison, WI			
9HIA28140 7/30/99	Inspection of Two Alleged Serious Patient Falls, Central Alabama Veterans Health Care System, Tuskegee, AL			
9HIA28141 7/30/99	Inspection of Alleged Substandard Patient Care and Administrative Discrepancies, Chattanooga Outpatient Clinic, Chattanooga, TN			
9HIA28145 8/11/99	A Review of the Policy and Function of the Veterans Health Administration's Deans Committees For Academic Year 1996			
9HIA28151 9/10/99	Inspection of Allegedly Inappropriate Open Heart Surgery Department of Veterans Affairs Medical Center West Los Angeles, CA			
9HIA28159 9/16/99	Inspection of Allegedly Inappropriate Visually Impaired Services, Department of Veterans Affairs Medical Center Augusta, GA			
9HIA28167 9/21/99	Inspection of the Management of a Missing Patient, Department of Veterans Affairs Medical Center Butler, PA			
TOTAL:	**102 Reports**	**$193,727,595**	**$173,003,000**	**$1,732,056**

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
8PEN02013 4/6/99	Claim, Contract No. V101bc131, Ambulatory Care Addition, VAMC San Juan, J. A. Jones Construction Co., Charlotte, NC	$3,787,571	
9PEN03106 4/6/99	Termination for Default, Cont. V673c-403, Construction, VAMC Tampa, David Boland, Inc., Titusville, FL		
9PEN02102 4/21/99	Proposal, Project No. 612-101f, A/E, SMP-SHG, VAOPC Fairfield, San Francisco, CA	$78,323	$68,334
9PEN03109 4/28/99	Claim, Contract No. V630c-415, Replace Fire Alarm System, VAMC Bronx, Eaton Electric, Inc., Bronx, NY	$28,053	
8PEN03002 5/3/99	Proposal, RFP 614-32-98, Radiologists - VAMC Memphis, TN, University of Tennessee, Memphis, TN	$98,115	$45,000
9PEN02104 5/12/99	Proposal, Project No. 600-401, A/E, VAMC Long Beach, HMC Group, Ontario, CA		$1,052,746
9PEN03107 5/12/99	Claim, Contract No. V621c-505, Correct Lake Drainage, VAMC Mountain Home, Carpenter Construction, Inc., Robbinsville, NC	$300,626	
9PEN03110 5/12/99	Proposal, RFP No. 646-37-98, Construction, VAMC Pittsburgh, TJR Enterprises, Pittsburgh, PA	$357,151	
8PEN03109 6/8/99	Proposal, RFP No. 688-67-97, Replace Essential Power, VAMC Washington, Ferguson & Ramey, Inc., Largo, MD		
9PEN02103 6/16/99	Claim, Project No. 610-090, Construction, VAMC Marion, Caddell Construction Co., Montgomery, AL	$122,999	
8PEN02108 6/29/99	Proposal, Project No. 640-042h, Road Improvements, VAMC Palo Alto, DJM/REZA Construction, Cerritos, CA		
9PEN03108 7/27/99	Proposal, Project No. 543-015, Sprinkler & Fire Alarm, VAMC Columbia, Fire Security System, Inc., Bossier City, LA	$1,109,745	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use	Unsupported Costs
9PEN03111 8/18/99	Claim, Contract No. V640p-5285, Transportation Services, VAHCS Palo Alto, Bay Trans Company, Inc., Santa Clara, CA	$1,463,111	
8PEN02007 9/15/99	Proposal, Project No. 614-011, Seismic/Modernization, VAMC Memphis, Caddell Construction Company, Memphis, TN	$1,912,868	
9PEN02108 9/15/99	Claim, Project No. 685-077, Roofing, VAMC Waco, Young Enterprises Sherman, TX	$442,774	
TOTALS:	**15 Reports**	**$9,701,336**	**$1,166,080**

The Defense Contract Audit Agency completed 14 of the 15 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 SEPTEMBER 30, 1999

Report Title, Number, and Issue Date	Questioned Costs	Recommended Better Use of Funds	Reason for Delay and Planned Date for a Decision
Contract Reviews by OIG			
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT			
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97), Wyeth-Ayerst Laboratories, Philadelphia, PA, 7PE-E02-127, 9/4/97		$5,484,450	Pending receipt of Contracting Officer Price Negotiation Memorandum (PNM); 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 M3-Q4-97), Medrad, Inc, Indianola, PA, 8PE-E02-084, 3/19/98		$2,468,847	Pending receipt of Contracting Officer PNM; anticipated award date is October 31, 1999.
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-Q3-97), Star Dental, Lancaster, PA, 8PE-E02-109, 6/3/98		$1,695,678	Pending receipt of Contracting Officer PNM; anticipated award date is October 31, 1999.
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	Resolution of recommendation pending availability of funds to pay claim; anticipated payment by October 31, 1999.

Report Title, Number, and Issue Date	Questioned Costs	Recommended Better Use of Funds	Reason for Delay and Planned Date for a Decision
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT (Cont'd)			
Audit of Claim for Alleged Damages Under an Agreement with a VAMC, 8PE-A12-104, 7/1/98		$318,008	Claim in litigation; no planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q4-97), Imation Enterprises Corporation Oakdale, MN, 8PE-E02-108, 7/20/98		$9,340,040	Claim in litigation; 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.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q4-97) Eastman Kodak Company, Rochester, NY, 9PE-X04-004, 11/30/98		$17,989,200	Pending receipt of Contracting Officer PNM; no planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Baxter Healthcare Corporation, Deerfield, IL, 9PE-X01-022, 2/4/99		$2,409,502	Pending receipt of Contracting Officer PNM; no planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-QF-98) Everest & Jennings, Earth City, MO, 9PE-E02-036, 2/23/99		$680,400	Pending receipt of Contracting Officer PNM; anticipated award date is October 31, 1999.

Report Title, Number, and Issue Date	Recommended Better Use of Funds	Unsupported Costs	Reason for Delay and Planned Date for a Decision
Contract Reviews by Other Agencies			
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT			
Claim, Contract V101DC-0048, Expand/Renovate Bldg-1, VAMC Salt Lake, Interwest Construction Salt Lake City, UT, 7PE-N03-114, 9/30/97	$1,469,934		Claim in appeal; planned resolution date not available.
Proposal, Contract No. V662C1404 Install Energy Management System, VAMC San Francisco, Ramlor Construction, Inc., Pleasanton, CA, 8PE-N03-118, 3/17/99	$298,715		Pending Board of Contract Appeal scheduling Alternative Dispute Resolution; no planned resolution date available.
OFFICE OF FACILITIES MANAGEMENT, VETERANS HEALTH ADMINISTRATION			
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. 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.
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; planned resolution date December 31, 1999.

Report Title, Number, and Issue Date	Recommended Better Use of Funds	Unsupported Costs	Reason for Delay and Planned Date for a Decision
OFFICE OF FACILITIES MANAGEMENT (Cont'd)			
Claim, Project Nos. 549-085/031 A/E, VAMC Dallas, Dahl Architects, Inc., /F&S Partner, Inc., Dallas, TX, 8PE-N02-110, 10/27/98			Negotiation not finalized; no planned resolution date available.
Claim, Project No. 580-040, Electrical, VAMC Houston, TX, Centex Bateson Construction Company, Inc., Dallas, TX, 5PE-N02-307, 2/18/99	$3,280,340		Negotiation not finalized; no planned resolution date available.
OFFICE OF THE GENERAL COUNSEL			
Claim, Project No. 632-062, 120 Bed Nursing Home Care Unit, VAMC Northport, J.F. O'Healy Construction Corporation, Bayport, NY, 3PE-N02-001, 3/26/96	$1,623,126		Claims consultant being hired by General Counsel to assist in resolving claim; no planned resolution date available.
Claim, Project No. 690-035 MFI Addition, VAMC Brockton, Saturn Construction Co., Inc., Valhalla NY, 6PE-N02-001, 5/19/97	$724,755		General Counsel in settlement discussions; no planned resolution date available.
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.
Proposal, Project No. 543-015, Sprinkler & Fire Alarm Pro, VAMC Columbia Fire Security Systems, Inc., Bossier City, LA, 8PE-N03-110, 3/19/98	$503,356		Claim in litigation; no planned resolution date available.
OFFICE OF GERIATRICS AND EXTENDED CARE, 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.

APPENDIX D

FOLLOWUP/RESOLUTION OF OIG RECOMMENDATIONS

The Inspector General Act Amendments of 1988 require identification of all significant management decisions with which the Inspector General is in disagreement and all significant and other recommendations unresolved for over 6 months (management decisions not made). We had no Inspector General disagreements on significant management decisions and there were no internal audit recommendations unresolved for over 6 months as of September 30, 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 April 1, 1999 – September 30, 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 September 30, 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.

TABLE 1 - SUMMARY OF UNRESOLVED AUDIT REPORTS

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

MONTHS	TYPE AUDIT	NUMBER	TOTAL
Over 6 Months	Internal Audit	0	31
	Contract Review	31	
Less Than 6 Months	Internal Audit	0	18
	Contract Review	18	
TOTAL			**49**

Tables 2 and 3 show a total of 43 reports that were unresolved as of September 30, 1999. This number differs from the 49 reports shown above because tables 2 and 3 include only reports with monetary benefits as required by the IG Act Amendments. Tables 2 and 3 also provide the reports resolved during the period with the OIG estimates of disallowed costs and funds to be put to better use, including those in which management agreed to implement OIG recommendations and those in which management did not agree to implement OIG recommendations. The Assistant Secretary for Financial Management maintains data on the agreed upon reports and Management estimates of disallowed costs and funds to be put to better use in order to comply with the reporting requirements for the Secretary's Management Report to Congress, required by the IG Act Amendments.

TABLE 2 - RESOLUTION STATUS OF REPORTS WITH QUESTIONED COSTS

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

RESOLUTION STATUS	NUMBER OF REPORTS	QUESTIONED COSTS (In Millions)
No management decision by 3/31/99	0	$0
Issued during reporting period	16	$1.7
Total Inventory This Period	**16**	**$1.7**
Management decision during reporting period		
Disallowed costs	16	$1.7
Allowed costs	0	$0
Total Management Decisions This Period	**16**	**$1.7**
Total Carried Over to Next Period	**0**	**$0**

Definitions:

- **Questioned Costs**

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

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

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

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

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

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

RESOLUTION STATUS	NUMBER OF REPORTS	RECOMMENDED FUNDS TO BE PUT TO BETTER USE (In Millions)
No management decision by 3/31/99	40	$226.3
Issued during reporting period	26	$205.9
Total Inventory This Period	**66**	**$432.2**
Management decisions during reporting period		
Agreed to by management	16	$214.4
Not agreed to by management	7	$101.6
Total Management Decisions This Period	**23**	**$316.0**
Total Carried Over to Next Period	**43**	**$116.2**

Definitions:

- **Recommended Better Use of Funds**

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

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

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

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

APPENDIX E

REPORTING REQUIREMENTS OF THE INSPECTOR GENERAL

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

IG Act References	Reporting Requirement	Page
Section 4 (a) (2)	Review of legislation and regulations	69
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-72
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-72
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	93
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	75
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	77-88 (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	94 (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	95 (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	89 to 92 (App. C)
Section 5 (a) (11)	Significant revised management decisions	None
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	None
Section 5 (a) (13)	Information described under section 05(b) of the Federal Financial Management Improvement Act of 1996	43

APPENDIX F

OIG OPERATIONS PHONE LIST

Investigations

Central Office Investigations Washington, DC ..... (202) 565-7702
Northeast Field Office (51NY) New York, NY ..... (212) 807-3444
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Newark Resident Agency (51NJ) Newark, NJ ..... (973) 645-3590
Pittsburgh Resident Agency (51PB) Pittsburgh, PA ..... (412) 784-3818
Washington Resident Agency (51WA) Washington, DC ..... (202) 565-8079
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Atlanta Resident Agency (51AT) Atlanta, GA ..... (404) 347-7869
Columbia Resident Agency (51CS) Columbia, SC ..... (803) 695-6707
Nashville Resident Agency (51NV) Nashville, TN ..... (615) 736-7200
New Orleans Resident Agency (51NO) New Orleans, LA ..... (504) 619-4340
West Palm Beach Resident Agency (51WP) West Palm Beach, FL ..... (561) 882-7720
Central Field Office (51CH) Chicago, IL ..... (708) 202-2676
Dallas Resident Agency (51DA) Dallas, TX ..... (214) 655-6022
Denver Resident Agency (51DV) Denver, CO ..... (303) 331-7673
Houston Resident Agency (51HU) Houston, TX ..... (713) 794-3652
Kansas City Resident Agency (51KC) Kansas City, KS ..... (913) 551-1439
Western Field Office (51LA) Los Angeles, CA ..... (310) 268-4268
Phoenix Resident Agency (51PX) Phoenix, AZ ..... (602) 640-4684
San Francisco Resident Agency (51SF) Oakland, CA ..... (510) 637-1074

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Healthcare Regional Office Atlanta (54AT) Atlanta, GA ..... (404) 347-2083
Healthcare Regional Office Chicago (54CH) Chicago, IL ..... (708) 202-5160
Healthcare Regional Office Los Angeles (54LA) Los Angeles, CA ..... (310) 268-3005

OIG OPERATIONS PHONE LIST (CONT'D)

Audit

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Contract Review and Evaluation Division (52C) Washington, DC .....(202) 565-4818
Financial Management Audit Division (52CF) Washington, DC.....(202) 565-7913
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Operations Division Seattle (52SE) Seattle, WA .....(206) 220-6654
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APPENDIX G

GLOSSARY

A&MM	Acquisition and Materiel Management
ADP	Automated Data Processing
AFIP	Armed Forces Institute of Pathology
AIG	Assistant Inspector General
CAP	Combined Assessment Program
C&P	Compensation & Pension
CFS	Consolidated Financial Statements
DCIS	Defense Criminal Investigative Service
dba	doing business as
DIC	Dependency and Indemnity Compensation
DoD	Department of Defense
DOL	Department of Labor
EEG	Electroencephalograph [System]
EMSHG	Emergency Medical Strategic Healthcare Group
FBI	Federal Bureau of Investigation
FOIA	Freedom of Information Act
FTE	Full Time Equivalent
FY	Fiscal Year
GAO	General Accounting Office
GPRA	Government Performance and Results Act
GSA	General Services Administration
HHS	Department of Health and Human Services
HUD	Department of Housing and Urban Development
IRS	Internal Revenue Service
IT	Information Technology
JWV	Jewish War Veterans of America
MCI	Master Case Index
MRI	Magnetic Resonance Imaging
NCA	National Cemetery Administration
NHCU	Nursing Home Care Unit
OA&MM	Office of Acquisition and Materiel Management
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
PACS	Picture Archiving and Communication Systems
PCIE	President's Council on Integrity and Efficiency
QMIS	Quarters Management Information System
QPA	Quality Program Assistance [Review]
RRB	Railroad Retirement Board
SSA	Social Security Administration
USSS	United States Secret Service
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VAM&ROC	Veterans Affairs Medical and Regional Office Center
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WCP	Workers' Compensation Program
Y2K	Year 2000

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in Front of the USAF Academy Chapel,
Colorado Springs, CO by
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VA OIG, Washington, DC

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Department of Veterans Affairs
Office of Inspector General
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