Office of Inspector General

Semiannual Report to Congress
October 1, 2002 - March 31, 2003

FOREWORD

I am pleased to submit the semiannual report on the activities of the Department of Veterans Affairs (VA), Office of Inspector General (OIG) for the period ended March 31, 2003. This report is issued in accordance with the provisions of the Inspector General Act of 1978, as amended. The OIG is dedicated to helping ensure that veterans and their families receive the care, support, and recognition they have earned through service to our country.

A total of 78 reports on VA programs and operations resulted in systemic improvements and increased efficiencies in areas of medical care, benefits administration, procurement, financial management, information technology, and facilities management. Audits, investigations, and other reviews identified $91 million in monetary benefits.

Our criminal investigators concluded 451 investigations involving a wide variety of criminal activity directed at VA personnel, patients, programs, or operations. During the semiannual period, special agents conducted investigations that led to 824 arrests, indictments, convictions, and pretrial diversions. They also produced $30 million in monetary benefits to VA (recoveries and savings). Two of our most significant investigations involved a VA police officer who was murdered while on duty at the VA medical center (VAMC) in Puerto Rico, and a Veterans Benefits Administration (VBA) employee who embezzled over $11.2 million from VA. The murder investigation led to the arrest of the alleged ringleader of a violent gang operating in a public housing complex in Puerto Rico. The embezzlement investigation concluded when the key player in the scheme received a 13-year prison term and was ordered to pay restitution of $11.2 million. In addition, criminal and administrative investigators, along with Hotline staff, accomplished 238 administrative sanctions.

Audit oversight of VA focused on determining how to improve service to veterans and their families. Preaward and postaward contract reviews identified monetary benefits of about $56 million resulting from actual or potential contractor overcharges to VA. Contract review recoveries have resulted in significant returns to VA's Revolving Supply Fund. Also, our audit of VA's information security controls and security management found that significant information security vulnerabilities continue to place the Department at risk of: (i) denial of service attacks on mission critical systems, (ii) disruption of mission critical systems, (iii) unauthorized access to and improper disclosure of data subject to Privacy Act protection and sensitive financial data, and (iv) fraudulent payment of benefits. Our recurring annual audit of the Department's

Consolidated Financial Statements resulted in an unqualified opinion and revealed material weaknesses involving information technology security controls and the integrated financial management system.

Healthcare inspectors focused on quality of care issues in VA. Inspectors visited a number of facilities in response to congressional and other special requests for assistance to review a variety of health care-related matters. For example, an inspection of the Contract Community Nursing Home (CNH) program found that the Veterans Health Administration (VHA) had taken years to implement standardized inspection procedures for monitoring CNH activities and for approving homes for participation in the program. In two other significant reports, we found that information security and privacy were not uniformly addressed throughout VA and that procedures for communicating abnormal test results need to be strengthened to ensure consistent application across VA.

The OIG's ongoing Combined Assessment Program (CAP) evaluated the quality, efficiency, and effectiveness of VA facilities. Through this program, auditors, investigators, and healthcare inspectors collaborated to assess key operations and programs at VAMCs and VA regional offices (VAROs) on a cyclical basis. The 12 CAP reviews and 3 CAP summary reviews completed during this reporting period highlighted numerous opportunities for improvement in quality of care, management controls, and fraud prevention. I am committed to extending this program to enable more frequent oversight of VA activities.

I look forward to continued partnership with the Secretary and the Congress in pursuit of world class service for our Nation's veterans.

Richard J. Griffin

RICHARD J. GRIFFIN
Inspector General

VA SUPERVISOR SENTENCED IN $11.2 MILLION FRAUD CASE

INSPECTOR GENERAL

Sarah Prater, a 30-year VA employee and a supervisor at the Atlanta VA Regional Office (VARO), was the last of 12 co-conspirators sentenced for an embezzlement scheme that netted them over $11.2 million. What started as a phone call to the VA Office of Inspector General (OIG) by an alert employee of the Naval Federal Credit Union (NFCU), resulted in an OIG team's discovery of the largest known embezzlement by a VA employee.

The embezzlement came to light when the NFCU employee received two large benefit disbursements from VA that were directed to the same account. Both payments were in the same amount, and made out to the same payee, but with two different VA claim numbers. The NFCU employee realized that someone needed to check further into this matter.

Athens Banner-Herald
Wednesday, December 4, 2002

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Story last updated at 10:06 p.m. on Tuesday, December 3, 2002

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Supervisor sentenced in fraud case

Associated Press

ATLANTA -- A former U.S. Department of Veteran Affairs supervisor was sentenced in federal court Tuesday to 13 years in prison without parole on charges of theft of more than $11 million from the VA.

Sarah Prater, 62, of Atlanta, was sentenced by U.S. District [illegible]

MULTIDISCIPLINARY TEAM BEGINS THE SEARCH

An OIG team composed of investigators, auditors, and information technology specialists discovered that Ms. Prater devised a scheme whereby she used her position of trust and the VA computer system to resurrect the claims files of deceased veterans who had no known dependents. Once the files were reestablished, she generated large retroactive payments and, in some cases, recurring monthly payments to her co-conspirators. After the payments were deposited in private bank accounts, the co-conspirators shared their bounty with Ms. Prater by giving her what amounted to approximately one-third of what they had received.

The OIG team established that a scheme started in July 1996, when Ms. Prater channeled funds to Kathy Eselhorst (a career VA employee who was retired) and Ernest Thornton (a former VA employee). Between 1996 and August 2001, the trio stole over $6 million. After Prater, Eselhorst, and Thornton were arrested, Prater's attorney indicated that she wanted to enter a plea. As a result, the

OIG investigative team and the U.S. Attorney's Office decided to continue looking at all claims files handled by Ms. Prater.

TWO SEPARATE SCHEMES UNCOVERED

What the OIG team then discovered was a second conspiracy that predated the one already uncovered. Starting in 1993, Ms. Prater embezzled approximately $5 million while working with a close friend, Billie Nell Ogletree, six of Ms. Ogletree's family members, and two other friends (a married couple). Prater and Ogletree devised a scheme whereby large lump sum payments and recurring monthly benefit payments were made to Ogletree's sons, daughters-in-law, grandson, and friends Henry and Barbara Roberts. Like the scheme with her coworkers, Prater received a share of the benefits when the large checks were cashed.

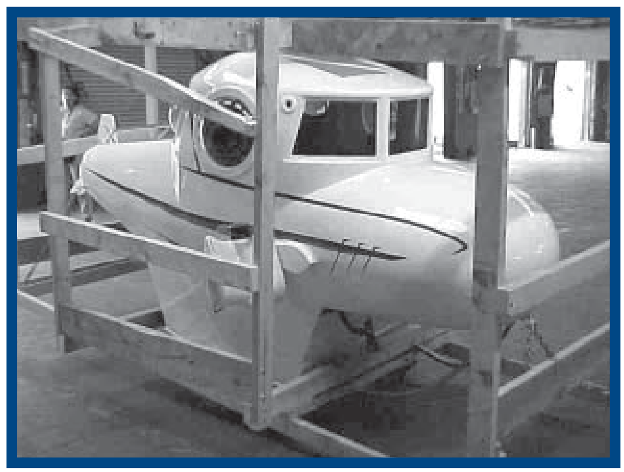
When the earlier scheme was identified, the team determined that the most effective investigative technique would be the simultaneous interviewing of all the subjects involved–especially based on intelligence about the subjects' criminal histories that included weapons and drugs. Early morning interviews with the suspects resulted in multiple confessions.

An interesting sidelight to this story is that Prater was simply the common denominator in the two separate conspiracies. One group of conspirators did not know about the other.

GUILTY AS CHARGED

The 12 co-conspirators pled guilty to various charges including theft of Government funds, conspiracy, and conspiracy to commit money laundering. Prater's guilty plea came after being indicted on 1,000 counts from the two conspiracies. In addition to defrauding VA, three of the co-conspirators also pled guilty to defrauding the Social Security Administration. The 12 defendants were sentenced to a total of 39.5 years' imprisonment, 38 years' probation, and judicially ordered to make restitution totaling over $34 million.

Prater was sentenced separately from her co-conspirators on December 4, 2002. She is presently serving a 13-year term in a Federal prison, to be followed by 3 years' supervised release. Her portion of the court ordered restituion was $11,224,741.20. The restitution in this case was ordered jointly and severally with her co-conspirators.



Two-person submarine recovered from the conspirators

PLANES, SUBS, AND AUTOMOBILES

During the investigation, over 100 bank accounts were analyzed to determine the disposition of the stolen money. The investigation generated 73 seizure warrants and 30 forfeiture recoveries.

Property with an appraised value of almost $2.8 million was seized or forfeited. This included houses, automobiles, and such oddities as a mini-submarine and an airplane. In addition, numerous bank accounts, insurance policies, cash, jewelry, valuable

A camper van was one of the many luxury items purchased by the conspirators during their spending spree with VA funds.

collections (including a $40,000 Barbie doll collection), antiques, cars, boats, and motor homes were recovered from the individuals involved.

THE INVESTIGATION EXPANDED

In order to ensure the integrity of the benefits delivery system, the Secretary of Veterans Affairs, Anthony J. Principi, requested the OIG conduct a departmentwide review. This project consisted of examining all one-time payments of $25,000 or more made by the Veterans Benefits Administration (VBA), as well as a review of active awards that were considered vulnerable to fraud based on previously developed characteristics associated with prior employee frauds. In addition, compliance with VBA's claims processing requirements by regional offices, information technology security, and the physical security of VA claims folders were also reviewed.

Although not like the scheme uncovered at the Atlanta VARO, one additional case of employee fraud was found following a review of 58,129 one-time payments and 2,129 fraud profile cases. The review team was able to conclude that payments were valid for 99.8 percent of the cases reviewed, with the balance of cases being associated with the Atlanta fraud situation.

Although the benefits delivery system and claims processing in general were free of any similar one-time pay fraud situations, the reviewers did find unacceptably high rates of noncompliance with internal control requirements related to one-time payment claims processing. As a result of our review, VBA began requiring that regional office management review all large one-time payments to ensure that they were appropriate and that required reviews were performed. In addition, it was recommended that the Under Secretary for Benefits ensure that security deficiencies discovered in the claims processing system be corrected, and that regional office managers certify annually that their claims processing security is in compliance with required controls.

Recovered SUV

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HIGHLIGHTS OF OIG OPERATIONS

This semiannual report highlights the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for the 6-month period ended March 31, 2003. The following statistical data highlights OIG activities and accomplishments during the reporting period.

DOLLAR IMPACT	Dollars in Millions
Funds Put to Better Use	$51.5
Dollar Recoveries	$19.5
Fines, Penalties, Restitutions, and Civil Judgments	$20.0

RETURN ON INVESTMENT

Dollar Impact ($91.0) / Cost of OIG Operations ($29.8)	3 : 1

OTHER IMPACT

Arrests	362
Indictments	160
Convictions	288
Pretrial Diversions	14
Administrative Sanctions	238

ACTIVITIES

Reports Issued	
Combined Assessment Program	15
Joint Review	1
Audits	8
Contract Reviews	30
Healthcare Inspections	15
Administrative Investigations	9
Investigative Cases	
Opened	480
Closed	451
Healthcare Inspections Activities	
Clinical Consultations	15
Hotline Activities	
Contacts	7,534
Cases Opened	605
Cases Closed	657

OFFICE OF INVESTIGATIONS

Overall Focus

The Office of Investigations focuses its resources on investigations that have the highest impact on the programs and operations of the Department. While continuing to target traditional "white collar" criminal activity associated with the operation of VA, personnel of the Criminal Investigations Division more frequently find themselves involved in the investigation of violent criminal activity such as murder, armed robbery, and terroristic or other threats – all of which are occurring on VA property and/or directed at VA personnel, patients, programs, or operations. The Administrative Investigations Division continues to concentrate its resources on investigating allegations against high-ranking VA officials relating to misconduct and other matters of interest to the Congress and the Department.

During this semiannual period, the Office of Investigations concluded 451 investigations resulting in 462 judicial actions (indictments, convictions, and pretrial diversions) and $30 million recovered or saved. Investigative activities resulted in the arrest of 362 individuals for committing crimes directed at VA programs and operations or crimes that were committed on VA property. In addition, 167 administrative sanctions were taken as a result of criminal investigations. The Administrative Investigations Division closed 15 cases, issuing 9 reports and 2 advisory memoranda. These investigations resulted in management agreeing to take 26 administrative sanctions, including personnel actions against 12 individuals and corrective action in 14 situations that will improve VA operations.

Veterans Health Administration

VA OIG special agents played a significant role in the investigation and arrest of 10 gang members for a variety of gang-related offenses in San Juan, Puerto Rico. Investigation revealed that the drug activities of the gang members were associated with the murder of a VA police officer during a robbery attempt at VA medical center (VAMC) San Juan. To date, one subject, alleged to be the "ringleader" of this vicious organized criminal group, has been indicted on Federal charges for the murder of the VA police officer. If convicted, the subject could face the death penalty.

In another suspicious death investigation by VA OIG agents, a nurse pled guilty to involuntary manslaughter and was sentenced to serve a 24-month prison term after investigators determined that the nurse administered an unauthorized dose of Diprivan, causing the death of the veteran 12 days later.

VA OIG agents also investigated and arrested a veteran with a long history of mental illness for making threats to VA personnel to include stating he was carrying out a "jihad" (holy war) against the VA facility at White River Junction, Vermont. The subject (who previously served prison time for possessing a handgun and bomb as he took a psychiatrist hostage) claimed that his van was full of explosives when law enforcement officials arrested him. With the assistance of the Federal Bureau of Investigation (FBI) and state police, the van was rendered safe after a bomb-detecting robot found no explosives. However, a subsequent search of the vehicle discovered various items that are currently undergoing forensic examination to determine if the items could potentially have been used to construct a bomb.

Veterans Benefits Administration

VA OIG agents investigated the owners and operators of a real estate business for equity skimming and mail fraud. OIG investigators determined that the subjects fraudulently represented themselves to financially distressed homeowners, took over the outstanding mortgages or tax payments, located outside investors to purchase the properties, and contacted the banks holding the mortgages to inform them of what they had done. The subjects were able to obtain the quitclaim deeds to the properties based on their promises. In turn, they would collect rent from the more than 168 properties under their control. Instead of paying on the mortgages, the subjects would use the rental proceeds for their personal gain. Two owners pled guilty and sentencing is pending.

Another Side of the VA OIG

An article appeared in a New York VA Regional Office (VARO) newsletter revealing the humanitarian side of the OIG by highlighting the efforts of OIG Special Agent (SA) Gerald Poto and regional office personnel in identifying a homeless man found dying in the streets of New York. After being admitted to a hospital, the admitting physician contacted the New York City missing persons unit and FBI for assistance in identifying the man. The matter was eventually turned over to the VA OIG and SA Poto began conducting interviews, facilitating fingerprinting, and eventually identifying the individual as a veteran who had previously been declared dead by a Texas court. SA Poto worked with the VARO to amend official VA records to reflect that the veteran was still alive. This allowed the veteran to be admitted to the warm, caring environment of the New York VAMC, where unfortunately he died, but with the dignity deserving of our Nation's veterans.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for $60 Million

Audits and evaluations were focused on operations and performance results to improve service to veterans. During this reporting period, 53 audits, evaluations, and reviews, including Combined Assessment Program (CAP) reviews, were conducted that identified opportunities to save or make better use of approximately $60 million.

Office of Management

The audit of the Department's Consolidated Financial Statements for Fiscal Years (FYs) 2002 and 2001 resulted in an unqualified opinion. The report on internal control discusses two material weaknesses involving: (i) inadequate information technology security controls, and (ii) lack of an integrated financial management system. The report also discusses three reportable conditions that, while not considered material weaknesses, are significant system or control weaknesses that could adversely affect the recording and reporting of the Department's financial information. The three conditions are: (i) application program and operating system change controls, (ii) loan guaranty business process, and (iii) operational oversight.

Contract Review and Evaluation

During the period, 30 contract reviews were completed - 18 preaward and 12 postaward reviews. These reviews identified monetary benefits of about $56 million resulting from contractor actual or potential overcharges to VA.

Office of Information Technology

An audit of VA information security controls and security management reported that, while progress has been made, much work remains to implement key information technology (IT) security initiatives, establish a comprehensive integrated VA security program, and fully comply with the Government Information Security Reform Act (superseded by the Federal Information Security Management Act). The audit found that significant information security vulnerabilities continue to place the Department at risk of: (i) denial of service attacks on mission critical systems, (ii) disruption of mission critical systems, (iii) unauthorized access to and improper disclosure of data subject to Privacy Act protection and sensitive financial data, and (iv) disbursements from VA benefit payment systems.

OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections (OHI) participated with the Offices of Audit and Investigations on 11 CAP reviews and reported on specific clinical issues warranting the attention of VA managers. OHI reviewed health care issues and made 46 recommendations and 49 suggestions to improve operations, activities, and the care and services provided to patients.

Inspection of the Contract Community Nursing Home (CNH) program found that the U.S. General Accounting Office and OIG advised VHA to address oversight and control vulnerabilities as far back as 1987. VHA policy for the program had been under review since 1995, and this slow pace of revising policy led to variances over time in the way local managers and clinicians administered and monitored CNH activities. Oversight controls and contract processes needed improvement to reduce the risk that veterans in CNHs will be subject to adverse incidents.

A summary evaluation of VHA's medical record security and privacy practices found that patient information security and privacy were not uniformly addressed across the VA. Another summary evaluation of VHA procedures for communicating abnormal test results found that guidelines needed to be strengthened to ensure consistent application across the VA.

In responding to congressional and other special requests and reviewing patient allegations pertaining to quality of care issues received by the OIG Hotline, OHI completed 20 Hotline cases, reviewed 61 issues, and made 41 recommendations. These recommendations resulted in managers issuing new and revised procedures, improving services, improving quality of patient care, and making environmental and safety improvements. OHI assisted the Office of Investigations on 15 criminal and fraud cases that required reviews of medical evidence, and monitored the work of VHA's Office of the Medical Inspector.

OFFICE OF MANAGEMENT AND ADMINISTRATION

Hotline

The Hotline provides an opportunity for employees, veterans, and other concerned citizens to report criminal activity, waste, abuse, and mismanagement. During the reporting period, the Hotline received 7,534 contacts and we opened 605 cases, of which 21 were from congressional sources. We closed 657 cases, of which 195 contained substantiated allegations (30 percent). The monetary impact resulting from these cases totaled almost $1.2 million. The cases also led to 45 administrative sanctions against employees and 68 corrective actions taken by management to improve VA operations and activities. Examples of some of the issues addressed by Hotline include improper disclosure of a veteran's sensitive information to a third party by a senior official, an improper personal and financial relationship between an employee and a patient, receipt of medical care totaling $450,000 by two ineligible veterans, patient safety violations, misuse of Government time and equipment in support of outside employment, and misconduct by VA employees.

Follow Up on OIG Reports

The Operational Support Division continually tracks the VA staff actions to implement OIG audits, inspections, and reviews. As of March 31, 2003, there were 65 open OIG reports containing 221 unimplemented recommendations with over $1 billion of actual or potential monetary benefits. During this reporting period, we closed 72 reports and 437 recommendations with a monetary benefit of $18 million after obtaining information that VA officials had fully implemented corrective actions.

Status of OIG Reports Unimplemented for Over 1 Year

The Federal Acquisition Streamlining Act of 1994 provides guidance on prompt management decisions and implementation of OIG recommendations. It states a Federal agency shall complete final action on each recommendation in an OIG report within 12 months after the report is finalized. If the agency fails to complete final action within this period, the OIG will identify the matter in their semiannual report to Congress. There are 10 OIG reports issued over 1 year ago (March 31, 2002, and earlier) with unimplemented recommendations. Six of these are VHA reports, one is a joint VHA and Office of Security and Law Enforcement report, and three are Veterans Benefits Administration (VBA) reports. We are especially concerned about the three reports on VHA operations, issued in 1996, 1997, and 1999, respectively, with recommendations that still remain open. Details about these reports can be found in Appendix B.

VA AND OIG MISSION, ORGANIZATION, AND RESOURCES

The Department of Veterans Affairs (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.

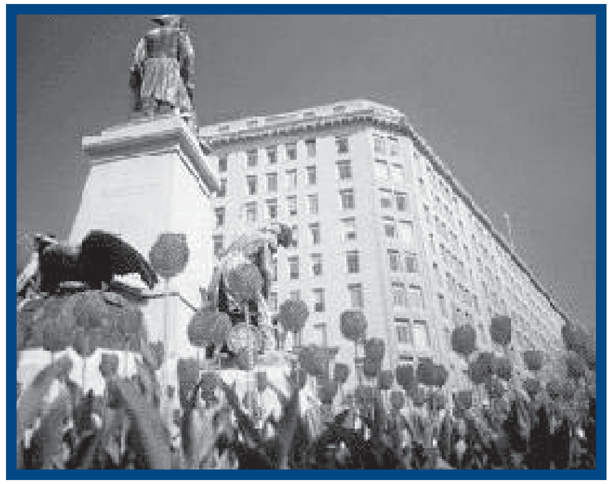
The Veterans Administration was founded in 1930, when Public Law 71-536 consolidated the Veterans' Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers.

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

Mission

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

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



VA Central Office
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 interment and memorial services.

To support these services and benefits, there are six Assistant Secretaries:
- Management (Budget; Finance; Acquisition and Materiel Management (A&MM));
- Information and Technology (I&T);
- Policy, Planning, and Preparedness (Policy; Planning; and Security and Law Enforcement (S&LE));
- Human Resources and Administration (Diversity Management and Equal Employment Opportunity; Human Resources Management (HRM); Administration; and Resolution Management);

- Public and Intergovernmental Affairs; and
- Congressional and Legislative 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 Utilization, the Center for Minority Veterans, the Center for Women Veterans, the Office of Employment Discrimination Complaint Adjudication, and the Office of Regulation Policy and Management.

Resources

While most Americans recognize the VA as a Government agency, few realize that it is the second largest Federal employer. For FY 2003, VA has approximately 211,000 employees and a $60.3 billion budget. There are an estimated 25.6 million living veterans. To serve our Nation's veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Philippines.

Approximately 193,000 of VA's employees work in VHA. Health care is funded at over $26.3 billion, approximately 44 percent of VA's budget in FY 2003. VHA provides care to an average of 59,000 inpatients daily. During FY 2003, VA expects to provide almost 51 million episodes of care for outpatients. There are 162 hospitals, 137 nursing home units, 206 veterans centers, 43 domiciliaries, and 856 outpatient clinics (including hospital clinics).

Veterans benefits are funded at $33.4 billion, about 55 percent of VA's budget in FY 2003. Approximately 13,000 VBA employees at 57 VA Regional Offices (VAROs) provide benefits to veterans and their families. Almost 2.8 million veterans and their beneficiaries receive compensation benefits valued at $25.2 billion. Also, $3.3 billion in pension benefits will be provided to veterans and survivors. VA life insurance programs have 4.2 million policies in force, with a face value of over $706 billion. VA expects 270,000 home loans to be guaranteed in FY 2003, with a value of almost $35 billion.

The National Cemetery Administration operates and maintains 120 cemeteries and employs over 1,500 staff in FY 2003. Operations of NCA and all of VA's burial benefits account for approximately $410 million of VA's budget. Interments in VA cemeteries continue to increase each year, with 91,000 estimated for FY 2003. Approximately 367,000 headstones and markers are expected to be provided for veterans and their eligible dependents in VA and other Federal 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 audits, investigations, and related operations into a cohesive, independent organization. In October 1978, the Inspector General Act (Public Law 95-452) was enacted, establishing a statutory Inspector General (IG) in VA.

Role and Authority

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

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

Organization

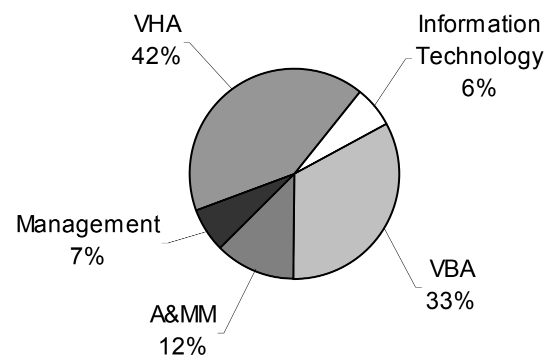
Allocated full-time equivalent (FTE) employees from appropriations for the FY 2003 staffing plan are shown below.

OFFICE	ALLOCATED FTE
Inspector General	4
Counselor	4
Investigations	136
Audit	176
Management and Administration	57
Healthcare Inspections	46
TOTAL	**423**

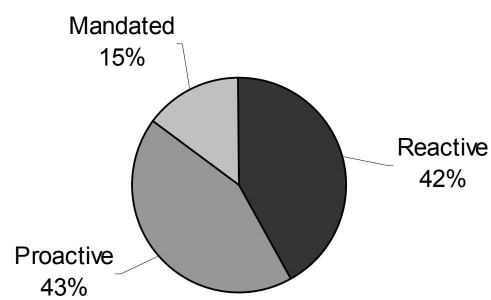
In addition, 25 FTE are reimbursed for a Department contract review function.

FY 2003 funding for OIG operations is $60.5 million, with $57.6 million from appropriations and $2.9 million through a reimbursable agreement. Approximately 69 percent of the total funding is for salaries and benefits, 5 percent for official travel, and the remaining 26 percent for all other operating expenses such as contractual services, rent, supplies, and equipment.

OIG resource allocation, by organizational element, during this reporting period, is shown as follows.



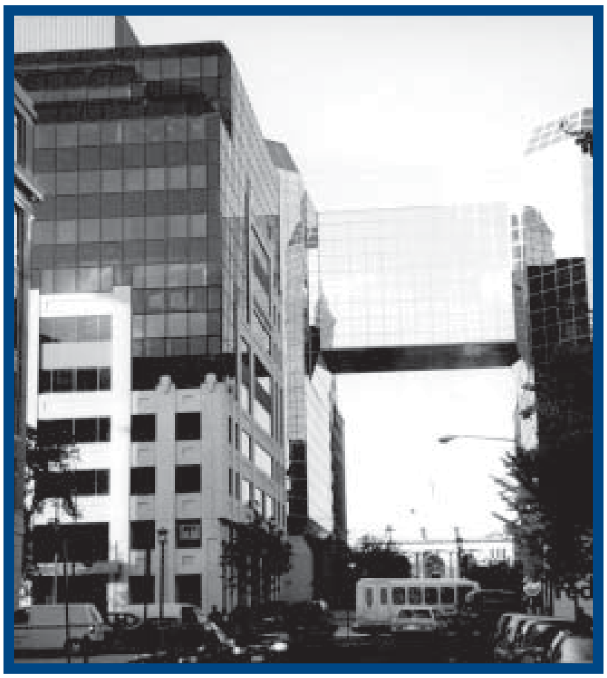
OIG resource allocation applied to mandated, reactive, and proactive work is shown below.



Mandated work is required by statute or regulation. Examples include our audits of VA's consolidated financial statements, oversight of VHA's quality assurance programs and Office of the Medical Inspector, follow up activities on OIG reports, and releases of Freedom of Information Act information.

Reactive work is generated in response to requests for assistance received from external sources concerning allegations of criminal activity, waste, abuse, and mismanagement. Most of the Office of Investigations' work is reactive.

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



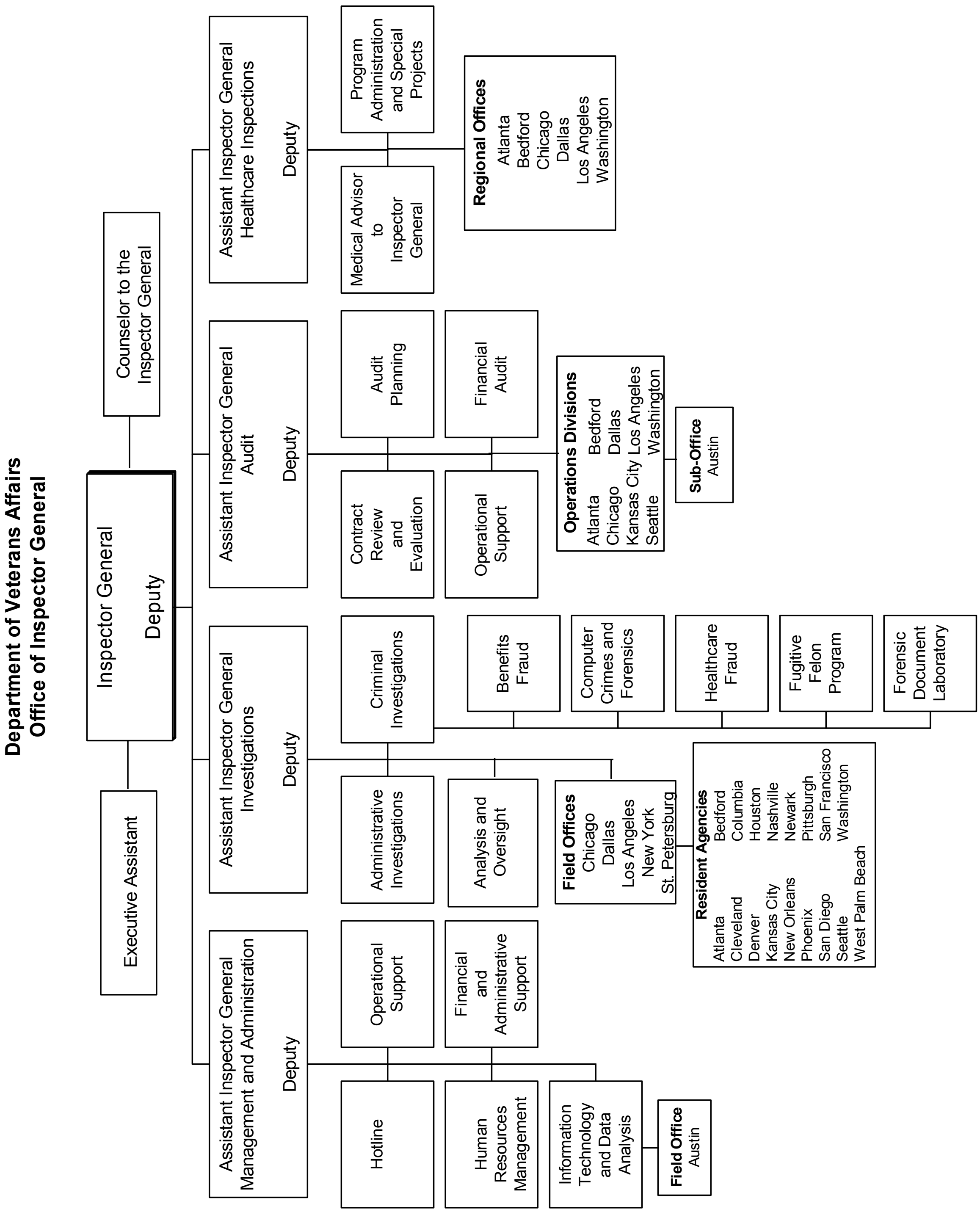
TechWorld, home to the VA Office of Inspector General

OIG Mission Statement

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

In performing its mandated oversight function, the OIG conducts investigations, audits, and healthcare inspections to promote economy, efficiency, and effectiveness in VA activities, and to detect and deter fraud, waste, abuse, and mismanagement. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer driven and results oriented.

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



Department of Veterans Affairs
Office of Inspector General
Inspector General
Deputy
Executive Assistant
Counselor to the Inspector General
Assistant Inspector General Management and Administration
Deputy
Hotline
Operational Support
Human Resources Management
Financial and Administrative Support
Information Technology and Data Analysis
Field Office
Austin
Assistant Inspector General Investigations
Deputy
Administrative Investigations
Criminal Investigations
Analysis and Oversight
Field Offices
Chicago
Dallas
Los Angeles
New York
St. Petersburg
Resident Agencies
Atlanta
Cleveland
Denver
Kansas City
New Orleans
Phoenix
San Diego
Seattle
West Palm Beach
Bedford
Columbia
Houston
Nashville
Newark
Pittsburgh
San Francisco
Washington
Benefits Fraud
Computer Crimes and Forensics
Healthcare Fraud
Fugitive Felon Program
Forensic Document Laboratory
Assistant Inspector General Audit
Deputy
Contract Review and Evaluation
Audit Planning
Operational Support
Financial Audit
Operations Divisions
Atlanta
Chicago
Kansas City
Seattle
Bedford
Dallas
Los Angeles
Washington
Sub-Office
Austin
Assistant Inspector General Healthcare Inspections
Deputy
Medical Advisor to Inspector General
Program Administration and Special Projects
Regional Offices
Atlanta
Bedford
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Dallas
Los Angeles
Washington

COMBINED ASSESSMENT PROGRAM

Reports Issued

During the period October 1, 2002 through March 31, 2003, we issued 12 CAP reports. Of the 12 CAP reports, 11 were for VA health care systems, VAMCs, and outpatient clinics, and 1 for a VARO. We also issued three CAP summary reports during this period.

Combined Assessment Program Overview - Medical

CAP reviews are part of the OIG's efforts to ensure that quality health care services are provided to our Nation's veterans. CAP reviews provide cyclical oversight of VAMC operations, focusing on the quality, efficiency, and effectiveness of services provided to veterans.

CAP reviews combine the skills and abilities of representatives from the OIG Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA health care systems and VA medical centers on a recurring basis.

Healthcare inspectors conduct proactive reviews to evaluate care provided in VA health care facilities and assess the procedures for ensuring the appropriateness of patient care and the safety of patients and staff. The facilities are evaluated to determine the extent to which they are contributing to VHA's ability to accomplish its mission of providing high quality health care, improved patient access to care, and high patient satisfaction. Their effort includes the use of standardized survey instruments.

Auditors conduct reviews to ensure management controls are in place and operating effectively. Auditors assess key areas of management concern, which are derived from a concentrated and continuing analysis of VHA, Veterans Integrated Service Network (VISN), and VAMC databases and management information. Areas generally covered include procurement practices, financial management, accountability for controlled substances, and information security.

Special agents conduct fraud and integrity awareness briefings. The purpose of these briefings is to provide VAMC employees with insight into the types of fraudulent and other criminal activities that can occur in VA programs and operations. The briefings include an overview and case-specific examples of fraud and other criminal activities. Special agents may also investigate certain matters referred to the OIG by VA employees, members of Congress, veterans, and others.

During this period, we issued 11 health care facility CAP reports. See Appendix A for the full title and date of the CAP reports issued this period. These 11 reports relate to the following VA medical facilities:

- VAMC Birmingham, Alabama
- Northern Arizona VA Healthcare System Prescott, Arizona
- VAMC West Palm Beach, Florida
- VAMC Atlanta, Georgia
- VAMC Boise, Idaho
- VAMC Lexington, Kentucky
- VAMC Alexandria, Louisiana
- VAMC Bronx, New York
- Chalmers P. Wylie VA Outpatient Clinic, Columbus, Ohio
- VAMC San Juan, Puerto Rico
- VA Salt Lake City Healthcare System, Utah

VA Medical Center
Boise, ID

Summary of Findings

Deficiencies identified during CAP reviews in the management of veterans health care programs were discussed in two recently issued OIG summary reports - Summary Report of CAP Reviews at VHA Medical Facilities, April 2001 through September 2002; and Summary Report of CAP Reviews at VHA Medical Facilities, October 2002 through December 2002. During this reporting period, OIG staff identified similar problems at the 11 facilities.

Procurement

The OIG identified the need to improve procurement practices in VA as one of the Department's most serious management challenges. We continue to identify control weaknesses in this area. Controls need to be strengthened to: (i) effectively administer the Government purchase card program, (ii) improve service contract controls, (iii) avoid conflicts of interest, (iv) improve contract administration, and (v) strengthen inventory management.

- Government purchase card controls were deficient at 7 of 11 facilities where we tested these issues. Policy and procedures governing the use of purchase cards, setting purchasing limits, and accounting for purchases were not followed.

- Service contract controls or contract administration efforts were deficient at 7 of 10 facilities where we tested these issues. Controls needed to be strengthened to ensure that acquisition and materiel management staff determines price reasonableness in noncompetitive contracts, and that contract provisions include procedures to help ensure contract compliance. Contract administration also needed improvement. For example, at one facility visited, none of the nine locally awarded clinical service contracts were forwarded to VACO to facilitate quality assurance and oversight.

- Medical supply inventory management was deficient at all 7 facilities, and nonmedical inventory management was deficient at 4 of 5 facilities where we tested these issues. We found that inventory levels exceeded current requirements resulting in funds being tied up in excess inventories.

Information Technology

A wide range of automated information system vulnerabilities were identified that could lead to misuse of sensitive information and data. VA had established comprehensive information security policies, procedures, and guidelines; however, CAP reviews found that facility policy development, implementation, and compliance were inconsistent. In addition, there was a need to improve access controls, contingency planning, incident reporting, and security training. We found inadequate management oversight contributing to inefficient practices, and to inadequate information security and physical security of assets. CAP findings complement the results of our FY 2002 Government Information Security Reform Act audit that identified information security vulnerabilities that place the Department at risk of: (i) denial of service attacks on mission critical systems, (ii) disruption of mission critical systems, (iii) unauthorized *access to and improper disclosure of data subject to Privacy Act protection and sensitive financial data, and (iv) fraudulent payment of benefits.*

- Information technology security deficiencies were found at all 11 VHA sites visited. We found that: (i) security plans were not prepared or were not kept current, (ii) contingency plans lacked key elements, (iii) access to VHA's Veterans Health Information Systems and Technology Architecture was not effectively monitored, and/or (iv) background investigations were not conducted on contract personnel working in sensitive areas.

Pharmacy

- VA has established policies, procedures, and guidelines for pharmacy security and accountability of controlled substances and other drugs. Pharmacy security and/or controlled substances accountability was deficient at 10 of the 11 facilities reviewed**.** The lack of management oversight at facility and VISN levels contributed to inefficient practices and to weaknesses in drug accountability and security.

- Controlled substance inspection procedures were inadequate to ensure compliance with VHA policy and Drug Enforcement Administration regulations at 9 of 11 facilities where controlled substances were reviewed. Unannounced inspections and inventories were not properly conducted, unusable drugs were not disposed of timely or properly, and discrepancies between inventory results and recorded balances were not reconciled in a timely manner.

- Improvements were needed in pharmacy security at 4 of 7 sites where security controls were reviewed. Security could be better enforced by restricting and consistently monitoring access to secured pharmacy areas, and by ensuring electronic alarm systems are appropriately connected and operational.

Part-Time Physician Time and Attendance

- VAMC managers did not have effective controls in place to ensure that part-time physicians were on duty when required by employment agreements at 6 of 10 facilities where we tested these controls. Physicians did not complete appropriate time and attendance records, and timecards were not posted based on the timekeepers' actual knowledge of physicians' attendance. Additionally, timekeepers did not receive annual refresher training or perform annual desk audits, as required by VA policy. As a result, physicians were paid for time when they were not present for their scheduled tours of duty. Because part-time physician time and attendance was not administered appropriately, there was no assurance VA received services required.

Health Care Management

- Inspectors reviewed the homemaker/home health aide program at 8 facilities. At 7 of 8 facilities, initial interdisciplinary patient assessments to determine clinical eligibility were not properly documented. Administrative oversight of program operations needed to be strengthened at 5 of 8 facilities. The need for continued services was not reviewed every 90 days, as mandated by VHA directive, in 3 of 8 facilities. At 3 facilities, program managers were not obtaining information

VA Medical Center
Bronx, NY

related to quality assurance from community health agencies providing services, as required by VHA directive. Formal agreements or contracts to ensure that rates were appropriate were not utilized at 3 facilities. Patient satisfaction with homemaker/home health aide services was high at all 8 facilities.

Survey Results

Inpatient Surveys

OHI completed 141 inpatient interviews in 9 VHA facilities during the semiannual period. We surveyed patients in the areas of medicine, surgery, mental health, intensive care, nursing homes, and special emphasis programs.

- Patients' perceptions of the care received at these facilities was rated favorable (over 80 percent) in most areas. Of a sample of 125, almost 1 in 8 patients (13 percent) felt their call lights were not answered within 5 minutes, and 19 percent (nearly 1 in 5) felt they were not advised about how to manage their care needs at home. Overall, 98 percent of the patients rated the quality of care to be excellent, very good, or good, a 23 percent increase from the last report. Results of these findings were discussed with facility managers during site visits.

VA Medical Center
Lexington, KY

Outpatient Surveys

We surveyed 200 VA outpatients at 10 facilities to ascertain their satisfaction with the care. We interviewed patients in primary care, mental health, or specialty care clinics. We also surveyed outpatients who were in waiting areas of the various supportive services such as pharmacy, radiology, and laboratory.

- Overall, 97 percent of the outpatients rated the quality of care as good, very good, or excellent. Ninety-five percent of the outpatients stated that they would recommend medical care to eligible family members or friends. Ninety-six percent of the respondents told us that their treatment needs were being addressed to their satisfaction.

- Eighty-six percent of the outpatients told us that they felt involved in decisions about their care.

- Conversely, only 67 percent of the outpatients told us that they were generally able to schedule appointments with their primary care providers within 7 days of their request.

- When outpatients were referred to specialists, only 68 percent told us that they were given appointments and were assessed by the specialists within 30 days of the referrals.

- Only 66 percent of the outpatients told us they received their prescriptions within 30 minutes; however, 83 percent stated that they received counseling by pharmacists when they received new prescriptions.

- Eighty-six percent of the respondents said that they received their refills in the mail before they ran out of their medications.

Physical Plant Environment

We inspected 59 clinical care areas at 8 facilities, including outpatient clinic areas, inpatient wards, emergency rooms, intensive care/coronary care *units, nursing home units, psychiatry units, and rehabilitation areas.*

- Inspections showed that some managers needed to improve ongoing processes to provide unobstructed hallways, ensure privacy, identify and provide better access to crash carts, secure medications, and maintain cleanliness. In addition, in some facilities, patient representatives' names, locations, and phone numbers were not posted for patients or family members who wanted to voice complaints or concerns. We discussed surveys with managers during site visits.

Employee Surveys

We surveyed employees at 10 facilities during this semiannual period using a combination of mailed and web-based questionnaires. We discussed the results of these surveys with managers during site visits.

- Seventy-six percent of the respondents believed that the quality of care at their respective facilities was either good, very good, or excellent. Seventy-one percent indicated that they would recommend treatment at their respective facilities to family members or friends.

- Sixty percent of the responding employees indicated that staffing was not sufficient in their respective work areas to provide adequate care to all patients. Eighty-three percent of the responding employees reported that they were generally comfortable in self-reporting errors that involved patient care, 72 percent indicated that they were comfortable reporting errors that involved colleagues, and 70 percent believed that reported errors were thoroughly investigated.

- Forty percent of employees indicated that housekeeping support was inadequate to maintain patient safety and general cleanliness. Thirty-four percent of employees reported that work orders for repairs were not addressed promptly.

Combined Assessment Program Overview - Benefits

Deficiencies identified during CAP reviews in the management of veterans benefits programs were discussed in a recently issued OIG summary report - Summary Report of CAP Reviews at VBA Regional Offices June 2000 through September 2002.

"The CAP reviews were both comprehensive and helpful and provided an independent audit which regional offices used to improve operations. VBA is extremely satisfied with the CAP reports received and with the opportunity to assist the OIG in refining the CAP review process."

Under Secretary for Benefits

During this reporting period, the OIG staff conducted a CAP assessment of VARO Nashville, Tennessee. The purpose of the review was to evaluate benefits claims processing, Benefits Delivery Network (BDN) security, and selected financial and administrative activities.

Summary of Findings

The CAP assessment of VARO Nashville, Tennessee, identified the following:

- Timeliness of compensation and pension (C&P) claims processing needed improvement. Avoidable processing delays and/or procedural errors affected workload and timeliness of service. Improved monitoring of pending workload could have detected errors and prevented delays in processing.

- Staff did not take timely or accurate actions on system error messages and notices of death of C&P beneficiaries, or perform supervisory reviews of awards when the benefit was less than $25,000 and

VA Regional Office
Nashville, TN

the one-time payment was retroactive for more than 2 years.

- VARO management needed to improve oversight of field examinations and analyses of fiduciary estate accountings to ensure that beneficiary assets are protected.

- Timeliness of vocational rehabilitation and employment claims processing needed improvement. Data was inaccurate and claims processing and case monitoring errors were noted.

- VARO management needed to ensure that all requests for loan guaranty convenience checks were adequately documented to reduce risk for fraud.

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 consists of three divisions.

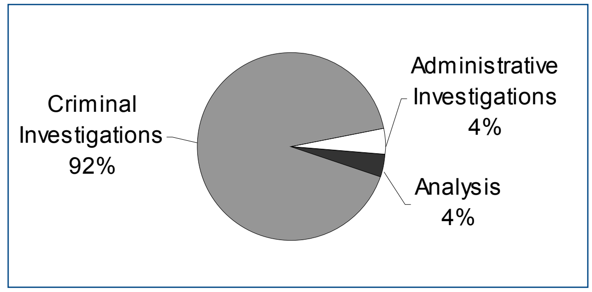
I. Criminal Investigations - The Division is primarily responsible for conducting investigations into allegations of criminal activities related to the programs and operations of VA. Criminal violations are referred to the Department of Justice for prosecution. The Division is also responsible for operation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

II. Administrative Investigations - 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 - 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 136 FTE allocated to the following areas.



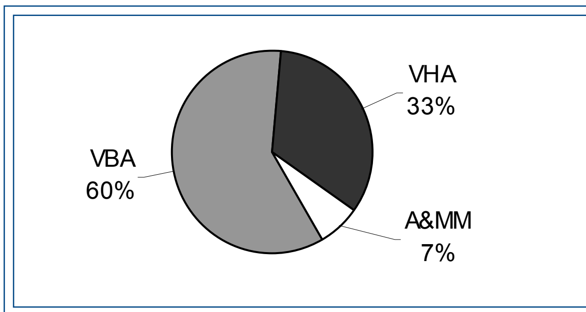
I. CRIMINAL INVESTIGATIONS DIVISION

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 124 FTE for its headquarters and 22 field locations. These individuals are deployed in the following VA program areas.



Overall Performance

Output

- 451 investigations were concluded during the reporting period.

Outcome

- Arrests - 362
- Indictments - 160
- Convictions - 288
- Pretrial Diversions - 14
- Monetary benefits - $30 million ($20 million - fines, penalties, restitutions, and civil judgments; $6.3 million - efficiencies/funds put to better use; and $3.7 million - recoveries)
- Administrative sanctions - 167

Customer Satisfaction

- Survey results showed an average rating of 4.9 out of a possible 5.0.

Veterans Health Administration

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

The Criminal Investigations Division investigates those instances of criminal activity against VHA that have the greatest impact and deterrent value. Working closely with VA police, the office has placed an increased emphasis on crimes occurring at VA facilities throughout the nation to help ensure safety and security for those working in or visiting VA medical centers. During this semiannual period, OIG special agents have participated in/or provided support to VA police in the arrest of 45 individuals who committed crimes on VHA properties.

Patient Abuse

- A nursing assistant was sentenced to serve 70 months' incarceration followed by 3 years' supervised release after being found guilty of one count of felony assault. The nursing assistant hit an elderly patient who was in restraints at the time of the attack.

Murder

- A joint investigation conducted by the VA OIG, VA police, FBI, U.S. Department of Housing and Urban Development (HUD), Food and Drug Administration (FDA), and the police of Puerto Rico led to the indictment of 9 members from the Luis Llorens Torres Public Housing gang on multiple drug charges and unlawful possession of firearms. Interrelated to the drug investigation, a gang member was indicted for murdering a VA police officer. If convicted of the murder of a Federal police officer, the gang member could potentially face capital punishment. All subjects are pending trial.

The San Juan Star, San Juan, PR — Thursday, February 20, 2003

Feds arrest 9 alleged members of Lloréns Torres drug gang

BY MARTY GERARD DELFIN
Of The STAR Staff

Federal authorities on Wednesday arrested nine members of an alleged drug gang, including one who was charged with the death of a Veteran Affairs police officer last April.

The purported traffickers operated from the Luis Lloréns Torres public housing complex in Santurce where they allegedly sold cocaine, crack, marijuana and heroin from the Las Malvinas section, authorities said.

Carlos Ayala López, known as "Macro," the alleged ringleader, was indicted on federal charges related to the shooting death of José Oscar Rodríguez Reyes, a Veteran Affairs officer, during a robbery attempt at the Veterans Hospital on April 24, 2002.

If convicted, the 25-year-old Ayala faces the death penalty.

Ayala was the only one of the nine men arrested who was charged with the shooting death.

Also indicted with conspiracy to distribute ...

González Vélez, 26.

Ramos Romero, known as "Joey Oreja," and Obregón Fontánez, known as "Angel Culón," were also charged with drug offenses while serving time in the Guayama prison and the federal Metropolitan Detention Center in Guaynabo. They were arrested at the correctional facilities.

Armed Robbery

- A joint investigation between the VA OIG, VA police, and FBI led to the arrest of an individual after it was determined that the individual conspired with two others in committing an armed robbery of a VAMC outpatient pharmacy. The other two individuals were previously indicted. Investigation established that one of the individuals posed as a flower delivery person to gain entry into the VAMC pharmacy. Upon entering, one subject displayed a shotgun as a second individual charged into the pharmacy and demanded that the narcotics vault be opened. The two suspects then ordered three pharmacy employees into the vault, tied their hands, and ordered them to the ground. They proceeded to steal large amounts of OxyContin and other narcotics with a street value estimated to be over $250,000. All three subjects are now pending trial.

Procurement Fraud

- A Grand Jury returned an indictment charging four officials of a manufacturing company with multiple violations of Federal procurement law. A joint investigation with the FDA Office of Criminal Investigations revealed that officials of the now defunct corporation manufactured, marketed, and sold over 160 sterilizers to Government and private hospitals nationwide. The corporation had not received premarket approval by FDA for safety or performance, a prerequisite to lawfully selling the systems. Each sterilization system was sold at an average cost of $100,000. Ten VAMCs purchased 12 systems at a total cost of approximately $1.1 million. The systems were purchased through individual VAMC contracts and on a Federal Supply Schedule contract.

Threats

- A veteran was indicted on various counts of mailing and telephoning threatening communications to VA employees. The

The Burlington Free Press
Burlington, VT
Friday, October 11, 2002

Threats catch up to troubled vet

The Vermont State Police bomb unit searched a minivan for explosives Thursday afternoon for several hours. No explosives were found. The van (below), belonging to Roger Dale Stockham, 55, of St. Albans, was parked near the Veterans Affairs Clinic at Fort Ethan Allen. Stockham, who has a history of mental illness, was arrested on a federal warrant.

investigation disclosed the veteran made threats to "take out the VA" and threatened the lives of VA employees. The veteran is a self-proclaimed terrorist and told the employees he was on a jihad (holy war). After an arrest warrant had been issued and while the individual was still at large, he contacted various news agencies and continued to make bomb threats against VA, threatened to kill a VA police officer, and appeared at a VA outpatient clinic stating to VA employees that his van was filled with explosives. At the VA outpatient clinic, he was arrested and his van was searched. Various devices were found, including propane, that if properly connected could have caused an explosion. No bomb was found in the vehicle. The veteran has an extensive criminal history, to include serving 10 years for planting a bomb at an airport. He is currently being held in Federal custody, awaiting trial.

Theft of Government Monies

- A clinical psychologist convicted of multiple counts of defrauding Federal and state health care programs was sentenced to 3 months' imprisonment and ordered to make restitution of $29,370. The term of imprisonment is to run concurrent with a sentence for Medicaid fraud and will be followed by 3 years' probation. Additionally, as a result of a civil suit filed against the psychologist for violating the False Claims Act, a default judgment of $102,271 was ordered as was a $20,000 fine. A joint investigation conducted with the state Office of the Attorney General, Medicaid fraud unit, confirmed the psychologist submitted claims for services he never provided.

Manslaughter

- A former VAMC nurse was sentenced to 24 months' imprisonment and 3 years' supervised release after pleading guilty to involuntary manslaughter. An investigation conducted jointly with the FBI revealed the nurse administered an unauthorized dose of the sedative drug Diprivan (also known as Propofol) to a veteran under his care. As a result, the veteran went into a coma, and died 12 days later. The nurse had originally been indicted for second-degree murder.

Sun-Sentinel
Ft. Lauderdale, FL
Thursday, October 31, 2002


LOCAL

Nurse admits killing man

Patient died 12 days after illegal injection

Theft of Government Property

- An individual was sentenced to serve 72 months' imprisonment and ordered to pay restitution of $12,000 after pleading no contest to dealing in stolen property. An investigation determined that a VAMC Government purchase card account number had been stolen and unauthorized purchases totaling $108,748 had been made for endoscopy equipment. The equipment was shipped from several companies and held for pick-up by the subject. Some of the property was recovered. The VA OIG and local law enforcement conducted this investigation jointly.

Theft of Benefits

- An individual was sentenced to 2 months' home detention and 3 years' probation, and ordered to make restitution of $1,150. The individual pled guilty to one count of making a false statement relating to health care matters for manufacturing a Department of Defense certificate of release or discharge from active duty form (DD Form 214) to receive VA medical benefits. The individual, a licensed pharmacist, attempted to use a cover story of post-traumatic stress disorder when he presented the fraudulent DD Form 214. The Assistant U.S. Attorney that prosecuted the case advised that the Federal felony conviction would also prohibit the individual from acting as a pharmacist in any capacity.

Veterans Benefits Administration

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

Death Match Project

- The VA OIG Information Technology and Data Analysis Division is conducting an ongoing proactive project in coordination with the Office of Investigations. The match is being conducted to identify individuals who may be defrauding VA by receiving VA benefits intended for veterans who have passed away. When indicators of fraud are discovered, the matching results are transmitted to VA OIG investigative field offices for appropriate action. To date, the match has identified 6,775 possible cases. Over 1,157 investigative cases have been opened. Investigations have resulted in the actual recovery of $7.6 million, with an additional $6.9 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $20.5 million. To date, there have been 70 arrests with several additional cases awaiting judicial actions.

Equity Skimming

- A husband and a wife were each charged with mail and bankruptcy fraud and sentenced to 10 years' and 6½ years' incarceration, respectively, after they were found to be operating a sophisticated equity-skimming scheme (which included dozens of VA properties) for several years. They also must make full restitution of $1.6 million to the victims of their criminal activity. The subjects convinced homeowners that they could rescue them from bank foreclosure by having the homeowners deed a partial interest in the property to their fictitious company. The subjects would then declare bankruptcy in the name of the fictitious company and obtain a stay of foreclosure. During the period that the stay of foreclosure was in place, the subjects would demand payments from the homeowners. The homeowners were falsely led to believe that the company was negotiating with the bank on a new repayment schedule. When the stay of foreclosure would finally be lifted, the bank would foreclose and the homeowners would be left with a larger debt.

- A Federal Grand Jury indicted an individual on multiple counts, including violations of bankruptcy fraud, false statements related to a bankruptcy, and mail fraud. The indictment was based on information gathered during a joint investigation by the VA OIG, FBI, and HUD OIG. The investigation revealed that the individual ran an equity-skimming scheme by purchasing numerous properties from VA and through HUD insured programs using false identifying information. The individual then rented the houses and kept the money for personal use rather than paying the mortgages. When the mortgage holders began foreclosure proceedings on the properties, the individual filed numerous bankruptcies to stall the foreclosures. Ultimately, all the properties went through foreclosure, resulting in a monetary loss exceeding $100,000 to the Government.

Fiduciary Fraud

- A veteran's fiduciary pled guilty to one count of fraudulent acceptance of payments. The individual could receive up to 5 years' imprisonment, a $250,000 fine, or both. The investigation disclosed the appointed financial guardian for this disabled veteran diverted in excess of $100,000 of the veteran's VA and Social Security benefits for her own personal use. In addition, she used the veteran's name and assets to qualify for a home loan.

Identity and Benefits Fraud

- The daughter of a deceased VA beneficiary pled guilty to one count of using a false means of identification. The joint VA OIG and U.S. Secret Service investigation disclosed the daughter assumed her deceased mother's identity in order to obtain and cash her mother's VA benefit checks.

After her mother died, VA continued to mail U.S. Treasury checks to the beneficiary's address from June 1989 to August 2001. In 1993, to further perpetuate the scheme, the daughter fraudulently obtained a state identification card in her mother's name and had a photo taken while wearing a wig and glasses. When the identification card expired, she returned to have it renewed. Fingerprint comparisons and handwriting exemplars confirmed the daughter negotiated all the checks issued by VA. The 12-year loss to VA totaled $133,366.

Education Benefits Fraud

- After a month-long civil trial in U.S. District Court, a jury found 19 defendants guilty of submitting false claims to the VA for educational assistance benefits. The 19 defendants are now liable to the Government pursuant to the False Claims Act for over $1.4 million in damages and penalties. This trial was the first successful civil jury trial of a False Claims Act case. The verdict in this trial now brings the total money recovered through civil and criminal actions in this case to over $4.5 million. This civil case stemmed from an investigation of a kickback scheme at a community college. The investigation, which included a 6-month undercover operation, disclosed that for more than 7 years about 400 veterans receiving VA educational benefits did not attend classes in which they were enrolled. Instead, these veterans paid kickbacks to instructors and their assistants in order to ensure that monthly certifications of attendance would be signed and passing grades would be received. Cases remain pending for 71 additional veterans involved who have refused to settle.

Theft and Embezzlement

- The VA OIG arrested a VAMC program officer, the former president of a local chapter of the American Federation of Government Employees. An investigation revealed that she knowingly and willfully took funds and personal property of the members of the local chapter. During the time period that she was president of the union (1998 to 2001), she embezzled approximately $60,000. She appeared before the U.S. Magistrate and was released on her own recognizance.

- A former VARO supervisor was sentenced on charges of theft of Government property and conspiracy to launder money. The supervisor, the last of 12 defendants sentenced in this case, was sentenced to 13 years' imprisonment and 3 years' supervised release, and ordered to pay over $11.2 million in restitution. The sentencing was the result of a massive VA OIG and FBI investigation that uncovered a scheme to manipulate VA records to arrange for and generate fraudulent retroactive disability benefits payments to co-conspirators. This OIG coordinated effort resulted in a successful investigation and prosecution that netted a cumulative total of 12 defendants, 474 months of incarceration, and over $34.4 million in restitution.

> ***"Recently read the article outlining the prison terms and fines received by the 12 cases of fraud your office discovered. Thank you for your dedication and professionalism your staff has displayed in bringing this scum to justice. I'm proud of my VA."***
>
> **A Disabled Combat Veteran**

Disability and Workers' Compensation Fraud

- A veteran was convicted on 11 counts of mail fraud and 2 counts of Federal employee disability fraud. This was a joint investigation between the VA OIG, U.S. Department of Labor OIG, and the U.S. Postal Inspection Service. The veteran made false and misleading statements and omitted material facts to the Government in order to qualify for disability and workers' compensation benefits to which he would not have otherwise been entitled. The veteran sought and received benefits for his alleged disability, when he was actively involved in physical activities including dancing, hunting, horseback riding, bull riding, and attending college full time. The rodeo bull riding by the veteran was recorded on videotape. The veteran's ex-wife gave a statement that the veteran used his cane and/or braces only on the days that he had a medical examination appointment with the VA or the post office. Loss to the Government was $87,410.

Contract Fraud

- A corporation was ordered to pay a $1 million criminal fine and restitution of $1.29 million to the U.S. Government for false underground storage tank testing services performed by the corporation. Federal facilities in 10 different Federal judicial districts were involved. The corporation had pled guilty to 10 felony counts of presenting false claims and making false statements to the Government. The pleas arose from an extensive investigation carried out by a task force involving several Federal criminal investigative agencies, in which agents observed the corporation testers at facilities across the country. The false tests ranged from failing to follow test protocol to "drive-by" tests where corporation testers were videotaped driving up to the facility, driving away after a few minutes, and then submitting false data for payment. The task force included agents from the VA OIG, Environmental Protection Agency OIG, U.S. Postal Service OIG, FBI, and Defense Criminal Investigative Service.

Theft of Benefits

- An information was filed charging a veteran with theft of Government funds. The investigation disclosed that the veteran, who was rated 100 percent disabled in 1998 for loss of the use of both feet, faked his disability in order to receive VA disability compensation benefits. The veteran claimed he could not walk without the use of braces, crutches, or a wheelchair. In fact, the veteran could walk without the assistance of these devices. Because of the nature of the veteran's disability, he also received money for the purchase and special adaptation of an automobile. The veteran also received compensation for special adaptive housing. Total loss to VA exceeds $450,000.

- A veteran was indicted on one count of theft of Government money, five counts of wire fraud, and one count of making a fraudulent material statement. For the last 17 years, the veteran has defrauded VA by claiming to have post-traumatic stress disorder due to his extensive combat experiences as a crew chief/door gunner on a helicopter in Vietnam. The veteran made claims that included being shot down 12 times, going on 4-5 combat missions per day, suffering shrapnel wounds, breaking his back in 8 places, having an ear drum blown out in a rocket attack, and being fired upon by the enemy every day that he was in Vietnam. The joint VA OIG and FBI investigation, which included interviews of his fellow soldiers, determined that the veteran was a helicopter mechanic who saw no combat in Vietnam. The loss to the Government is $162,000.

- The nephew of a deceased veteran was sentenced to serve 5 years' probation and ordered to make restitution to VA of $147,203. Results of a death match with the Social Security Administration (SSA) disclosed the veteran died in March 1990, but VA was not notified of his death. A VA OIG investigation revealed the nephew submitted VA pension verification reports on which he forged the signature of his deceased uncle. Additionally, the nephew fraudulently opened a joint bank account by forging his deceased uncle's name. For more than 10 years, the perpetrator accessed VA funds intended for his deceased uncle and converted these funds to his own use.

- As a result of a joint investigation between the VA OIG and a fraud task force, a veteran was indicted and arrested on charges that he defrauded VA by falsely claiming 10 children as dependents, causing an increase in his VA pension benefits. In addition, he defrauded charitable organizations and Government agencies involved in providing financial disaster relief to the families of those killed in the terrorist attacks on the World Trade Center. The indictment alleges the individual falsely reported that his wife died in the terrorist attacks in order to obtain more than $136,000 in financial aid and disaster relief from various charities, and attempted to obtain at least $76,000 in benefits from other charities and Government agencies. The total loss to VA was $19,034.

- A veteran was charged with five counts of fraud and false statements and subsequently arrested. The veteran had been receiving 100 percent VA disability and VA individual unemployability benefits since 1999. He was also receiving workers' compensation from the U.S. Postal Service for a back injury he claimed was totally debilitating. However, video surveillance caught him mowing grass, lifting heavy equipment, repairing vehicles, and playing basketball for lengthy periods of time. The aggregate Government loss is $158,911, of which $71,938 represents the VA overpayment. This successful action resulted from a joint inquiry conducted by the VA OIG and U.S. Postal Service.

- A veteran and a conspirator were indicted and were subsequently arrested on one count of conspiracy, eight counts of wire fraud, and seven counts of mail fraud. The veteran sought funding through VA's vocational rehabilitation self-employment plan for expenses involving a bus transportation business. The veteran was specifically told that VA regulations did not allow for the purchase of new buses, but that he could refurbish two buses that he allegedly owned to a like new condition. The veteran and a mechanic then became involved in a conspiracy to defraud VA by submitting $450,000 in fraudulent invoices sent through the mail for allegedly refurbishing two buses. The joint VA OIG and Postal Inspection Service investigation revealed that all of the invoices were fraudulent and rather than refurbishing 2 buses, the veteran purchased 28 buses. The mechanic, who received the $450,000 after the submission of the fraudulent invoices, turned all of the money (except for $10,000) over to the veteran. The VA OIG has seized all 28 buses, which are being sold to recover some of the VA monies. The total loss to VA for funding this veteran's self employment plan was $634,000, which included costs for advertising, business consultants, and accountants.

Conspiracy and Bank Fraud

- A VA employee and three other individuals were indicted on one count of conspiracy and eight counts of bank fraud. The joint investigation between the VA OIG, VA police, and U.S. Secret Service determined the employee stole U.S. Treasury checks payable to homeless veterans whose checks were addressed to a VAMC. The employee subsequently provided the stolen checks to one individual for negotiation at several banks in return for monetary compensation. Further investigation revealed that two additional individuals facilitated the negotiation of the stolen checks and also received monetary compensation. The total loss is $90,264.

Federal Mail Fraud

- The president of a construction company was sentenced to 24 months' incarceration and 3 years' probation, and ordered to pay restitution of $1.5 million. He previously pled guilty to Federal mail fraud charges. Between 1994 and 1997, this contractor received multiple VA construction contracts for VAMC renovation work. In addition, he had contracts with the Army, Navy, and U.S. Postal Service. The president of the company applied (by mail) for and received Government progress payments by certifying that his suppliers and subcontractors had been paid. However, as the president of the company well knew, he consistently failed to pay the suppliers and subcontractors. As a result of his action, a total of 10 significant Government construction programs were delayed, valued small businesses suffered financial difficulties, and his bonding company declared bankruptcy. As part of the sentencing, the president of the company has been barred for life from receiving any future Government contracts.

Bribery

- An individual waived indictment and pled guilty to a one-count information charging him with bribery. He admitted that from 1998 to 2001, while employed as a VAMC transportation specialist, he received bribes from an automobile repair company to approve work on VA vehicles that was not needed, not done, and/or previously billed. In return, the president of the company gave the individual items of value, cash, and checks. The individual admitted that the amount of the fraudulent charges incurred by his actions cost the Government between $120,000 and $200,000.

Fugitive Felon Program

The Office of Investigations has established a fugitive felon program to identify VA benefits recipients as well as VA employees who are fugitives from justice. The program conducts computerized matches between fugitive felon files of law enforcement organizations and VA personnel records as well as files of veterans who have received benefits from VA. Information on the identified fugitives is provided to law enforcement organizations to assist in apprehension. Fugitive information is then provided to VA to suspend benefit payments and initiate recovery action.

To date, Memoranda of Understanding/ Agreements have been completed with the U.S. Marshals Service, the State of California, and most recently, the National Crime Information Center. Still in the initial phase, the program has identified more than 10,000 matches. Two recent investigations dealing with fugitives are detailed below.

- A VA beneficiary had been wanted for several years for parole violations involving attempted distribution of cocaine, attempted possession with intent to distribute cocaine, and the Bail Reform Act. The VA OIG and U.S. Marshals Service located the beneficiary at an address reflected in his VA claim folder. He was apprehended and turned over to authorities for further processing.

- VA OIG agents along with state investigation agents arrested a fugitive wanted on a parole violation warrant for aggravated kidnapping. The VA OIG provided intelligence and assisted in field operations. The OIG also provided information that resulted in ultimately terminating the fugitive's benefits checks. Photographs were circulated and a briefing was given to the VARO on the fugitive status of the veteran. Several months later, the fugitive attempted to enter the VARO to inquire about the status of his benefits checks, but he was turned away by security because he had a knife on his person. A member of the VARO recognized the fugitive from the pictures and immediately alerted the VA OIG. Agents were able to take the fugitive into custody and to subsequently turn him over to the state investigation agents.

OIG Forensic Document Laboratory

The OIG operates a nationwide forensic document laboratory service for fraud detection that can be used by all elements of VA. The types of requests routinely submitted to the laboratory include handwriting analysis, analysis of photocopied documents, and suspected alterations of official documents.

There were a total of 24 completed laboratory cases during this semiannual period.

Laboratory Cases for the Period	
Requester	Cases Completed
OIG Office of Investigations	9
VA Top Management	2
VA Regional Offices	12
Office of Security and Law Enforcement	1
Total	**24**

The following are examples of completed laboratory reports.

- The theft of a veteran's identity led to a $248,000 loss for VA involving both financial and medical benefits. A VA OIG investigation developed evidence that was submitted to the laboratory for examination. Through handwriting and fingerprint analysis, the laboratory determined that the veteran's brother, who had no prior military service, stole the identity and proceeded to obtain various VA benefits.

- VA OIG investigated a veteran who allowed a person with no prior military record to use his identity to facilitate treatment at a VAMC. During the same time period, this same veteran proceeded to use the identity of yet another veteran to receive treatment at a VAMC as well as to steal a U.S. Treasury check made payable to the true veteran. The laboratory determined that the check endorsement was a forgery. Fingerprint examinations linked the thief to the stolen check.

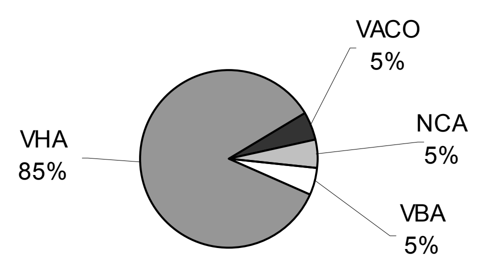
II. ADMINISTRATIVE INVESTIGATIONS DIVISION

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 six FTE allocated. The following chart shows the percentage of resources used in reviewing allegations by program area.



Overall Performance

Output

- The Division closed 15 cases.

- The Division issued nine reports (including one on a case still open) and two advisory memoranda. Five cases resulted in administrative closures.

Outcome

- VA managers agreed to take 26 administrative sanctions, including personnel actions against 12 officials, and corrective actions in 14 instances to improve operations and activities. The corrective actions included directing an employee to return fees and donations improperly accepted from pharmaceutical companies; issuing bills of collection to recoup salary paid to a physician for hours not worked, and to recoup appropriated funds used for personal expenses; transferring compensation received by employees from the general post fund to the U.S. Treasury; and developing a policy addressing the receipt of honoraria.

A sample of the Administrative Investigations Division reports issued during this period is provided below. These reports address serious issues of misconduct against high-ranking officials and other high profile matters of interest.

Veterans Health Administration

Nonprofit Research and Education Corporation

- An administrative investigation substantiated that a medical center director and the executive director of the affiliated nonprofit research and education corporation used the corporation's funds for unauthorized purposes, including public relations activities, meals, transportation, and uniforms. The medical center director, who received thousands of dollars in cash from the nonprofit corporation, did not deposit or account for the funds as required. The corporation's executive director also did not retain petty cash disbursement records as required. VHA management agreed to take appropriate administrative action against the medical center director, and to ensure action was taken against the corporation's executive director.

Acceptance of Pharmaceutical Company Fees and Donations

- An administrative investigation substantiated that a pharmacy chief violated the Standards of Ethical Conduct for Employees of the Executive Branch by accepting fees from pharmaceutical companies for speaking on topics related to his official duties, and by engaging in speaking activities, paid for by pharmaceutical companies, that conflicted with his official duties. The chief attempted to distance himself from the pharmaceutical companies by channeling fees through a third party, but knew that pharmaceutical companies were the source of the fees and personally arranged to accept them. The investigation further substantiated that the pharmacy chief violated the Standards of Ethical Conduct by accepting donations from pharmaceutical companies, through the affiliated medical school, to pay for his travel and other expenses. The donations were, in effect, gifts to him. VHA officials agreed to take appropriate administrative action against the chief for these improprieties, direct him to return the fees and donations he improperly accepted, and take other corrective action.

Physician Time and Attendance

- Two administrative investigations substantiated that three full-time physicians misused their official time by treating non-VA patients at affiliated medical schools, for compensation, during their VA tour of duty. The supervisors of two of the physicians were aware of their activities. VHA agreed to take appropriate administrative action against the three physicians and the supervisors, and to recoup the salary paid to one of the physicians when he was not present at VA.

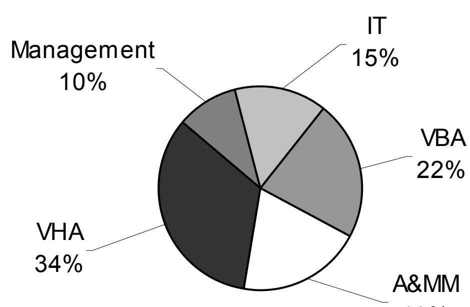
OFFICE OF AUDIT

Mission Statement

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

Resources

The Office of Audit has 176 FTE allocated for its headquarters and 8 operating divisions located throughout the country. The following chart shows the allocation of resources used in auditing each of VA's major program areas.



In addition, the Office of Audit's Contract Review and Evaluation Division has 25 FTE authorized for reimbursement under an agreement with the VA Office of Acquisition and Materiel Management. This division conducts preaward and postaward reviews of certain categories of VA contracts.

Overall Performance

Output

- We issued 23 audits, evaluations, and reviews for an output efficiency of 1 report per 6.8 FTE during this 6-month period. We also issued an additional 30 contract review reports, for an efficiency of 1.2 reports per FTE for the 6-month period.

Outcome

- Recommendations to enhance operations and correct operating deficiencies have associated monetary benefits totaling approximately $3.5 million. In addition, contract reviews identified monetary benefits of about $56 million associated with the performance of preaward and postaward contract reviews.

Customer Satisfaction

- Customer satisfaction with performance and financial audits and evaluations during this reporting period was 4.0 on a scale of 5.0. The average customer satisfaction rating achieved for contract reviews was 4.3 out of a possible 5.0.

Audits completed during the period identified opportunities to improve services to veterans, and identified savings that could be used to increase services to veterans. The following summarizes some of the audits completed during the reporting period organized by VA component: VBA, Office of Management, and Office of Information Technology.

Veterans Benefits Administration

Implementation of Government Performance and Results Act of 1993 in VA

Issue: Data used to compute the rehabilitation rate was not accurate.
Conclusion: VBA needs to provide additional training and enhance accountability of supervisors.
Impact: Accuracy of the rehabilitation rate.

The audit was conducted to determine whether the data used by VBA officials to report the rehabilitation rate for FY 2000 was accurate. This audit was one in a series of audits assessing the accuracy of data used to measure VA performance in accordance with the Government Performance and Results Act of 1993. Audit results show that data used to compute the rehabilitation rate reported for FY 2000 was not accurate. Accordingly, we cannot attest to the accuracy of the rehabilitation rate included in VA's Annual Accountability Report for FY 2000. To improve the accuracy of data used to compute the rehabilitation rate, we recommended the Under Secretary for Benefits: (i) provide additional training for VARO personnel who make decisions to classify veterans as rehabilitated or discontinued, and (ii) enhance accountability of VARO supervisors for those decisions. In addition, we recommended that VBA headquarters officials strengthen oversight of VARO personnel to ensure the decisions to classify veterans as rehabilitated or discontinued were timely and accurate. The Under Secretary concurred with our recommendations and provided acceptable implementation plans. *(Accuracy of VA Data Used to Compute the Rehabilitation Rate for FY 2000, 01-01613-52, 2/6/03)*

Office of Management

VA's Consolidated Financial Statements

Issue: VA's Consolidated Financial Statements for FYs 2002 and 2001.
Conclusion: Audit resulted in an unqualified opinion, but significant control weaknesses and noncompliance items still remain.
Impact: Improved stewardship of VA assets and resources.

The OIG contracted with the independent public accounting firm Deloitte & Touche LLP to perform the audit. The OIG defined the requirements of the audit, approved the audit plans, monitored the audit, and reviewed the draft reports. The independent auditors' report provided an unqualified opinion on VA's FY 2002 and 2001 consolidated financial statements. We agree with the auditors' opinion and with the conclusions in the related report on VA's internal control over financial reporting and compliance with laws and regulation.

The auditors' report on internal control discusses two material weaknesses concerning: (i) information technology security controls, and (ii) integrated financial management. The report also discusses three reportable conditions that, while not considered material weaknesses, are significant system or control weaknesses that could adversely affect the recording and reporting of the Department's financial information. The three reportable conditions are: (i) application program and operating system change controls, (ii) loan guaranty business process, and (iii) operational oversight.

The report on compliance with laws and regulations continues to conclude that VA is not in substantial compliance with the financial management system requirements of the Federal Financial Management Improvement Act of 1996. The internal control issues concerning an integrated financial management system and information technology security controls indicate noncompliance with the requirements of the Office of Management and Budget (OMB) Circular A-127, "Financial Management Systems," which incorporates by reference OMB Circulars A-123, "Management Accountability and Control," and A-130, "Management of Federal Information Resources."

The Assistant Secretary for Management stated he concurs with the reported findings and recommendations. We will follow up on these findings and evaluate implementation of corrective actions during our audit of VA's FY 2003 consolidated financial statements. *(Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2002 and 2001, 02-01638-47, 1/22/03)*

Preaward Contract Reviews

Issue: Federal Supply Schedule (FSS) vendors' best prices.
Conclusion: Vendors can offer better prices to VA.
Impact: Potential better use of $37 million.

Preaward reviews of four FSS and direct delivery offers contained recommendations that have the potential better use of $37 million. Recommendations to negotiate lower contract prices were made because the manufacturers were not offering the most favored customer prices to FSS customers when those same prices were extended to commercial customers purchasing under similar terms and conditions as the FSS.

Issue: Health care resource contracts.
Conclusion: VA can negotiate reduced contract costs.
Impact: Potential better use of $3 million.

We completed reviews of 14 proposals from VA affiliated medical schools involving the acquisition of scarce medical specialists' services. We concluded that the contracting officers should negotiate reductions of $3 million to the proposed contract costs because of differences between the proposed costs for the services solicited and the costs the affiliate could justify during the reviews.

Postaward Contract Reviews

Issue: Contractor overcharges for pharmaceuticals and medical supplies.
Conclusion: Overcharges were disclosed.
Impact: Recovery of more than $16 million.

- We completed nine reviews of vendors' contractual compliance with the specific pricing provisions of their FSS contracts. The reviews resulted in recoveries amounting to $16 million.

- We completed three drug pricing Public Law 102-585 compliance reviews at pharmaceutical vendors, with recoveries of $133,000.

OIG efforts to maintain an aggressive postaward contract review program resulted in numerous companies' submitting voluntary disclosures and refund offers for overcharges on their contracts with VA. Postaward contract reviews are a major source of recoveries to VA's Revolving Supply Fund. These recoveries are a result of VA's work as a team, with the Office of Acquisition and Materiel Management, Office of General Counsel, and VHA, participating in an effort to ensure that VA's contracts are fairly priced.

Office of Information and Technology

Security Controls

Issue: VA's information security program.
Conclusion: VA's programs and sensitive data are vulnerable to destruction, manipulation, and inappropriate disclosure.
Impact: Improved automated data processing security.

The audit evaluated VA information security controls and security management. While progress has been made, much work remains to implement key IT security initiatives, establish a comprehensive integrated VA-wide security program, and fully comply with the Government Information Security Reform Act (superseded by the Federal Information Security Management Act). The audit found that significant information security vulnerabilities continue to place the Department at risk of: (i) denial of service attacks on mission critical systems, (ii) disruption of mission critical systems, (iii) unauthorized access to and improper disclosure of data subject to Privacy Act protection and sensitive financial data, and (iv) fraudulent payment of benefits. Based on the audit results, VA information security should continue to be identified as a Department material weakness area under the Federal Managers' Financial Integrity Act.

During the course of the audit, we advised the Department's Chief Information Officer (CIO) that we would be recommending that the Department centralize authority for implementation of security remediation efforts. This year's security audit has shown that VA requires a coordinated and focused security program to address its significant information security vulnerabilities. The Department's decentralized management approach has not worked, with a continuing unacceptable security posture for the Department as a whole. On August 6, 2002, the Secretary of Veterans Affairs issued a memorandum centralizing the Department's IT security program, including authority, personnel, and funding, in the Office of the Department CIO, effective October 1, 2002. In response to our request, the CIO provided details on the centralization of the IT security program under his office. We made a series of recommendations to the CIO to address the information security vulnerabilities identified by the audit. The CIO agreed with the findings and recommendations and provided acceptable implementation plans. However, the completion of some of VA's priority security remediation efforts is dependent on receipt of additional budget resources. Necessary budget resources need to be obtained as soon as possible to complete all of VA's priority security remediation efforts. This will provide the opportunity to improve VA's information security posture and reduce the level of risk to VA operations. *(Audit of the Department of Veterans Affairs Information Security Program, 01-02719-27, 12/4/02)*

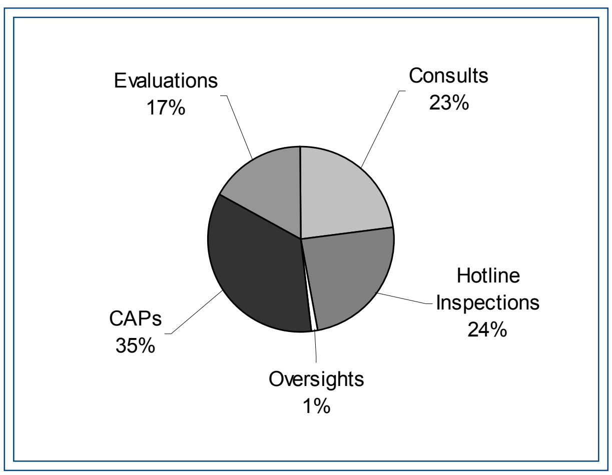
OFFICE OF HEALTHCARE INSPECTIONS

Mission Statement

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

Resources

The Office of Healthcare Inspections (OHI) has 46 FTE allocated to staff headquarters and field operations. The following chart shows the allocation of resources utilized to conduct evaluations, inspections, CAP reviews, oversight, and clinical consultations in support of criminal cases.



Overall Performance

Output

- Participated in 11 CAP reviews to evaluate health care issues and made 46 recommendations and 49 suggestions that will improve operations and activities, and the care and services provided to patients.

- Completed 1 national program review and 2 summary evaluations and made 22 recommendations to improve patient care and safety in contract nursing homes, and to enhance communication of abnormal test results and medical record privacy and security controls.

- Completed 20 Hotline cases, which consisted of reviews of 61 issues. Administratively closed 8 of the cases and issued reports on the remaining 12 cases. Made 41 recommendations that will improve the health care and services provided to patients.

- Provided clinical consultative support to investigators on 15 criminal cases.

- Oversaw the work of VHA's Office of the Medical Inspector on 2 projects.

Outcome

- Overall, OHI made or monitored the implementation of 109 recommendations and 49 suggestions to improve the quality of care and services provided to patients and their families. VHA managers agreed with all of our recommendations and provided acceptable implementation plans. VHA implementation actions will improve clinical care delivery, management efficiency, and patient safety, and will hold employees accountable for their actions.

Customer satisfaction

- Survey results showed an average rating of 4.5 out of a possible best score of 5.0.

Veterans Health Administration

Summary Evaluations

Issue: Community nursing home (CNH) program.
Conclusion: Actions were needed to strengthen the oversight process and reduce occurrence of adverse incidents.
Impact: Improved monitoring of veterans' care and reduced risk of adverse events.

We conducted an evaluation of the CNH program to follow up on VHA's efforts to strengthen its monitoring of CNH activities and to ensure that veterans receive good care in safe environments. We found that the U.S. General Accounting Office and OIG advised VHA to address oversight and control vulnerabilities as far back as 1987. VHA policy has been under review since 1995. We believe this slow pace of revising policy led to variances in the way local managers and clinicians administer and monitor CNH activities. VHA published new CNH policy at the conclusion of this review; however, it still warranted clarification and stronger controls.

The veterans we visited were generally well cared for and mostly satisfied with CNH services and accommodations. We found 9 reported cases of abuse, neglect, and financial exploitation during our reviews of the records of 111 veterans residing in 25 CNHs. This represented an average 8 percent incident rate in the sample population. We also found veterans not in our sample and non-veterans residing in VHA-contracted CNHs who were subjected to serious adverse incidents. These conditions emphasized the need for VHA to strengthen its oversight controls.

We found similar program vulnerabilities identified during previous U.S. General Accounting Office and OIG reviews continue to exist. Not all VHA CNH review teams analyzed Health and Human Services Center for Medicaid and Medicare Services data. This was evidenced by the fact that 27 percent of the veterans at the medical facilities visited were placed in Medicaid and Medicare Services "watch listed" homes. The medical facilities we visited had active contracts with 41 CNHs on the watch list. The 41 CNHs were cited 273 times for administrative and quality of care violations.

We found that CNH contract procedures and inspection practices varied among VA medical facilities. Contracts needed to be standardized. Medical record documentation needed improvement. In addition, clinicians needed to routinely obtain performance indicators to better monitor occurrences at the CNH facilities and to coordinate performance improvement initiatives. We also found that VHA CNH review teams do not meet annually with VBA fiduciary and field examination supervisors to discuss veterans of mutual concern, as required by VBA policy. The absence of this communication link impedes VA's ability to adequately protect veterans from financial exploitation and protect VA-derived payments.

We made 10 recommendations to VHA, and the Under Secretary for Health agreed with all but one issue, pertaining to monitoring patients who reside outside a 50-mile radius of VA facilities. We agreed that no immediate action was needed on this issue, but we encouraged VHA managers to closely oversee the adequacy of monitoring these veterans. The Under Secretary for Health provided acceptable implementation plans for the remaining recommendations. The Under Secretary for Benefits agreed with our recommendation to coordinate efforts with VHA in this area and establish proper procedures for exchanging information. *(Healthcare Inspection – Evaluation of VHA's Contract Community Nursing Home Program, 02-00972-44, 12/31/02)*

Issue: Communication of abnormal test results.
Conclusion: Care could be improved by timely communication to providers and patients.
Impact: Timely treatment of patients' abnormal test results.

We reviewed the adequacy of VHA communication procedures for conveying abnormal test results to treatment providers and patients. Managers at clinical laboratories visited had established provider notification guidelines for communicating abnormal test results; however, compliance with the procedures varied. Collectively, policies in laboratory, pathology, radiology, and primary care would benefit from a comprehensive national VHA policy on communicating abnormal test results to treatment providers and patients. Clinicians in the three diagnostic services (clinical laboratory, anatomic pathology, and radiology) had evidence in the records of notifying providers in 330 (83 percent) of the 400 abnormal test results reviewed.

Efforts were needed to ensure that diagnostic clinicians document on their test reports when they notify providers of the results. Some patients did not receive follow up care within 30 days of their abnormal diagnostic tests because the patients did not keep their scheduled appointments, or the providers were not notified of the abnormal results. There were also problems with contacting the patients once they left the medical center (i.e., incorrect addresses or telephone numbers). Managers at these facilities assured us that they would review the patients in our sample, contact each patient who did not receive follow up care, and provide the necessary care. The review also found that managers needed to evaluate the effectiveness of the view-alert system to ensure that the responsible treatment providers are notified of all abnormal x-ray results. We made four recommendations to the Under Secretary for Health, who agreed with the recommendations and provided acceptable implementation plans.

(Healthcare Inspection – Evaluation of VHA Procedures for Communicating Abnormal Test Results, 01-01965-24, 11/25/02)

Issue: Medical record privacy and security.
Conclusion: Opportunities exist to improve practices.
Impact: Enhanced effectiveness of procedures for securing medical record data.

We conducted a review to evaluate VAMCs' compliance with VHA's medical record privacy policies and security practices. We assessed whether the physical layout of patient care areas supported medical record privacy, examined internal control procedures used to monitor employee access to restricted computer-based patient records, evaluated incident reporting systems, determined the adequacy of formal education and training programs regarding protection of patient medical records and management of confidential information, and measured employees' knowledge of computer security policies and procedures and educational opportunities related to medical record privacy. We found that the physical layout of nursing stations in several patient care areas hindered employees from providing adequate medical record data privacy. Seventy-eight percent of the employees we surveyed acknowledged that they did not consistently log off their computers before leaving their workstations. Eighty-seven percent of patient care areas inspected had designated containers for disposal of sensitive patient information close to employee workstations; however, the containers were often uncovered and unsecured. We found that managers did not consistently monitor access to restricted computer-based patient medical records. Only 50 percent of the medical centers inspected had formalized automated information systems incident reporting systems, and 7 percent of the employees surveyed felt it was acceptable to share their computer access and verify codes with co-workers. Two VAMCs did not have full-time information security officers and policies pertaining to the need for employees to maintain auditory privacy needs improvement.

We made seven recommendations to strengthen medical record security and privacy practices. The Under Secretary for Health concurred with our recommendations and provided acceptable implementation plans. *(Healthcare Inspection – Evaluation of VHA Medical Record Security and Privacy Practices, 01-01968-41, 12/24/02)*

Healthcare Inspections

Issue: Suspicious deaths.
Conclusion: Actions were needed to ensure appropriate level of care and timeliness of treatment.
Impact: Improved care and services for inpatients.

We did not substantiate allegations of three suspicious deaths. However, in one case, we did identify several patient care lapses concerning one patient. As this patient was seriously ill throughout the hospitalization, we could not say with certainty whether these lapses affected his outcome.

VA Medical Center
San Juan, PR

Inspection results showed the patient needed to be placed in a medical intensive care bed, or an equivalent level of care, but action was not taken to ensure this occurred. We also found that the patient apparently did not receive nutrition for 10 days. Nurses did not adequately document the patient's physical assessment findings. Furthermore, pharmacy personnel did not timely notify the ordering physician when a prescribed antibiotic was not available in the pharmacy.

We did not substantiate the allegation that another patient at the medical center suffered a delay in diagnosis or treatment, or that yet another patient did not receive adequate care in the emergency room. We also did not substantiate a general allegation that unsanitary conditions caused a disproportionate number of infections at the medical center. We made five recommendations to improve care and services. The VISN Director and VAMC Director concurred with the findings and provided acceptable implementation plans. *(Healthcare Inspection – Patient Care and Management Issues at the Department of Veterans Affairs Medical Center San Juan, Puerto Rico, 01-02341-02, 10/4/02)*

Issue: Wound care.
Conclusion: Nurses did not provide adequate care for a patient's wound.
Impact: Improved wound care.

We substantiated an allegation that nurses did not adequately care for a patient's wound. The patient's treatment record showed that nursing employees only provided wound care and dressing changes an average of 1.2 times a day during the period in question, while the physician's order was for 3 times a day. A medical center surgeon, who provided consultation on wound management, also expressed concern about the frequency of the patient's dressing changes. The attending physician on this matter told us that the condition of the wound supported a conclusion that the patient's dressings were not changed as frequently as ordered. Nursing records also did not adequately show that nurses took pressure ulcer-prevention measures, made appetite and diet tolerance assessments, or flushed his intravenous line. During the course of our inspection, we identified a communication problem between the facility's medical team and the urology consultant service. Communication between these two groups needed improvement to ensure that all clinicians were working to provide coordinated care. We made six recommendations to improve care and services. The VISN Director and VAMC Director concurred with the findings and provided acceptable implementation plans. *(Healthcare Inspection – Patient Care Issues, Greater Los Angeles Healthcare System Los Angeles, California, 02-01221-01, 10/4/02)*

Issue: Infection controls.
Conclusion: Opportunities exist to improve the environment of care.
Impact: Improved cleanliness and patient safety.

The Secretary of Veterans Affairs asked us to review concerns he received from Senator Christopher Bond and Congressman Kenny Hulshof regarding complaints of substandard VA care. A complainant alleged that an inpatient was found to have maggots in a foot wound and also expressed concern about sanitary conditions at the hospital. We concluded that the maggot incident was not reflective of inadequate infectious disease controls. We substantiated the allegation that there were environment of care and quality control issues in need of improvement, but managers acted promptly to correct the issues. We made two recommendations to correct environment of care concerns. The Acting VISN Director agreed with the recommendations, with one clarification, and provided acceptable implementation plans. *(Healthcare Inspection – Infection Control and Patient Care Issues, Harry S. Truman Memorial Veterans Hospital Columbia, Missouri, 02-02177-05, 10/10/02)*

Issue: Patient discharges from inpatient psychiatry.
Conclusion: Inappropriate patient discharge.
Impact: Improved patient safety and discharge planning practices.

Franklin Delano Roosevelt Campus
VA Hudson Valley Healthcare System
Montrose, NY

We reviewed the deaths of three patients following their medical center discharges, and an alleged denial of treatment to a fourth patient. We substantiated that one patient’s discharge from inpatient psychiatric treatment was not appropriate. Also, we found that clinicians had not adequately documented their clinical or administrative rationale for denying one patient’s request for additional inpatient post-traumatic stress disorder treatment. We made five recommendations regarding discharge planning, notification of family members, management of residential care homes, and documentation of medical records and denied admission requests for care. The VISN and Medical Center Directors agreed with the recommendations and provided acceptable implementation plans. *(Patient Care Issues, Department of Veterans Affairs Hudson Valley Health Care System Franklin Delano Roosevelt Campus, Montrose, New York, 02-02374-08, 10/10/02)*

Issue: Post-operative care.
Conclusion: Clinician involvement in patient care needed improvement.
Impact: Improved discharge planning processes.

We reviewed allegations from a complainant who questioned the appropriateness of a patient's care and the patient's premature discharge to a community nursing home. We concluded that the patient received inadequate post-operative care. The patient was ill and chronically debilitated. There should have been more immediate physician involvement in his care than was the case when he started to show signs of clinical deterioration soon after his admission to the nursing home care unit. We made four recommendations to better document and communicate discharge-planning processes. The VISN Director agreed with the recommendations and provided acceptable implementation plans. *(Healthcare Inspection – Discharge Planning and Other Patient Care Issues at the VA Northern Indiana Healthcare System, 01-02748-07, 10/25/02)*

Issue: Unexpected patient deaths.
Conclusion: Patient care and monitoring needed improvement.
Impact: Improved patient safety.

We conducted an inspection to determine the validity of quality of care complaints regarding unexpected deaths. An anonymous complainant alleged that a patient died from overmedication. The complainant alleged a second patient died as the result of employee misconduct. We did not substantiate the allegation that a patient died from overmedication, but we did determine that the care and monitoring of the patient could have been improved. Employees did not check the patient's personal belongings for contraband, and nurses did not take or did not record the patient's vital signs at one prescribed interval. Nurses also did not perform suicide prevention checks the day the patient died. We did not substantiate the allegation that the second patient died because of employee misconduct. However, employees did not carry out certain assigned patient care responsibilities. Managers took administrative actions by suspending these employees. We made three recommendations. The VISN Director concurred with the recommendations and provided acceptable implementation plans. *(Healthcare Inspection – Patient Care and Employee Conduct Issues, VA New Jersey Healthcare System East Orange, New Jersey, 01-01340-14, 11/13/02)*

East Orange Campus
VA New Jersey Health Care System
East Orange, NJ

Issue: Patient abuse.
Conclusion: Nurse managers needed to investigate allegations of patient abuse.
Impact: Improved patient safety and employee training.

We reviewed allegations concerning patient care and management issues. We found that employees reported serious concerns about a certified nursing assistant; however, the nurse manager (NM) discounted the reports and did not conduct inquiries, as required by policy. In addition, the NM falsely testified that she never received any information of this kind about the certified nursing assistant. Had the NM acted to address employees' concerns, the patient may not have been subjected to physical abuse. VA managers conducted their own internal reviews, and acted to revise their patient abuse policy to require notifying

VA police in all cases of suspected patient abuse and to require immediate family notification by nurse management. VA managers hired a night shift supervisor and formed a team to address employee morale issues. Although employees received additional training on the patient abuse policy and other related issues after the incident, many employees, including senior supervisors, remained uncertain about the procedures related to the reporting of adverse incidents.

We recommended the VISN Director and VA Healthcare Center Director take administrative action against the NM for not addressing repeated concerns expressed by employees. We also required employees to receive additional training. The VISN Director concurred with the findings and recommendations and provided acceptable implementation plans. The NM in question was detailed from her position to a non-supervisory assignment. Soon afterwards, the NM resigned from VA and moved out of state. *(Healthcare Inspection – Patient Treatment Issues, Orlando VA Healthcare Center, Orlando, Florida, 02-01980-34, 12/16/02)*

Issue: Patient treatment lapses.
Conclusion: Physicians were not providing timely treatment.
Impact: Improved timeliness of patient assessment and care.

We reviewed allegations that managers and physicians did not ensure high quality medical and surgical care for certain patients. Our review showed that clinicians had not assessed one patient for 3 consecutive days during the patient's hospitalization for an acute care episode. We also substantiated a delay in ordering medications for one other patient. While, in our opinion, the two patients did not suffer adverse effects from these treatment lapses, the standard of care was not met.

We recommended that the VISN Director instruct quality managers to determine whether these were isolated incidents or whether systemic weaknesses existed. Specifically, we asked for data concerning whether clinicians are visiting inpatients daily, and timely ordering and distributing pharmacy orders. We asked that the VISN Director refer these results to the OIG for further review. The VISN Director concurred with the findings and recommendations and provided acceptable implementation plans. The Health Care System Director established a monitor to track the timeliness of provider assessments of patients on acute units. He also agreed to examine the procedures for ordering medications. *(Healthcare Inspection – Medical and Surgical Care Issues at the Department of Veterans Affairs Northern Indiana Health Care System Fort Wayne, Indiana, 02-00265-35, 12/16/02)*

Issue: Infection control.
Conclusion: VA clinicians did not follow policy related to follow up after exposure to body fluids and accident reporting.
Impact: Improved employee safety.

We reviewed allegations pertaining to access to care, quality of care, nurse staffing, and employee safety at a VA medical facility. With the exception of the need to strengthen certain safety controls, we did not substantiate the allegations. Patients were not denied access to care, and managers took proper measures to ensure that mentally ill veterans received appropriate treatment through other VA facilities or contractors. VISN investigators thoroughly evaluated a surgeon's complication rates and found that the rates remained within the national average. VISN managers are now requiring all reported complications to be sent through the performance improvement committee for oversight purposes, and the surgeon's rates will be monitored. We did not find a correlation between adverse patient events and staffing levels in the nursing home care unit or the intensive care unit. However, we found that a VA supervisor and a contract medical officer of the day did not follow prescribed policies related to follow up after an employee's exposure to body fluids and accident reporting. We made five recommendations. The VISN Director concurred with the recommendations and the VA medical facility Director provided acceptable implementation plans. *(Healthcare Inspection – Quality of Care Issues, Amarillo VA Health Care System Amarillo, Texas, 02-02706-45, 1/10/03)*

Amarillo VA Health Care System
Amarillo, Texas

Issue: Nursing care and documentation.
Conclusion: Nursing employees had not properly monitored and documented IV line access.
Impact: Improved care.

We conducted an inspection to determine whether a patient received inadequate medical care. The complainant, who visited the patient regularly, alleged that employees provided the patient insufficient intravenous (IV) line care, inadequate nutrition support, inadequate nursing care in the nursing home care unit, and delayed treatment by repeatedly postponing his scheduled surgery. We substantiated the allegation that employees had not adequately documented that they monitored the patient's IV line, as required by policy. An abscess at the IV site strongly suggested that nursing employees did not follow IV procedures. We did not substantiate the allegation that the patient received insufficient nutrition care or that the postponement of the third stage of the patient's surgery resulted in an inappropriate treatment delay. We were unable to substantiate or refute the allegation of poor nursing home care because of the length of time that lapsed since the alleged incident and lack of direct evidence. We found that the patient experienced a second allergic reaction to a prescribed medication because employees had not appropriately flagged the medical record to alert future providers. Local policy did not clearly define which clinical team member was responsible for flagging allergies in the medical record. We made four recommendations. The Acting Healthcare System Director and the VISN Director concurred with the findings and recommendations and provided acceptable implementation plans. *(Healthcare Inspection – Medical Treatment Issues, VA Greater Los Angeles Healthcare System Los Angeles, California, 02-00003-56, 2/2/03)*

Issue: Hepatitis C treatment.
Conclusion: Clinicians' treatment met standards. The liver clinic needed increased resources.
Impact: Improved timeliness of services and access to care.

We received a request from the Secretary of Veterans Affairs to investigate an allegation that a veteran with hepatitis C received substandard care. Allegations also included tampering with his medical record, not scheduling timely appointments in the liver clinic, and not assigning a primary care provider to the patient.

We did not substantiate the allegation of substandard care. The patient apparently developed toxic hepatitis as a result of a change in the herbal over-the-counter medications he was taking. This toxic condition was superimposed upon his chronic hepatitis C infection. The medical care the patient received for his hepatitis C infection met the standard of care. We found no evidence to support the allegation that the patient's medical record had been tampered with in an effort to cover up poor care.

We concluded that it was questionable whether the liver clinic had sufficient staffing resources and that the patient was not assigned a primary care provider. We made two recommendations to improve care and services. The VISN Director and the VAMC Director concurred with the findings and provided acceptable implementation plans. *(Healthcare Inspection – Care Provided to Patient with Hepatitis C, Washington, DC, VA Medical Center, 02-02514-13, 11/4/02)*

VA Medical Center
Washington, DC

Issue: Medical oxygen system.
Conclusion: The oxygen piping was safe for patient use.
Impact: Substantiated patient safety.

We initiated an inspection based on allegations that the VA Medical and Regional Office Center had a centrally piped medical oxygen system that was contaminated. We met with VHA facilities management officials to obtain the services of an independently selected medical gas verifier with recognized credentials. The individual selected was certified by the Medical Gas Health Professional Organization and was a member of the National Fire Protection Association Technical Committee on Industrial and Medical Gases. We witnessed the testing of both the old and new oxygen piping by the independent verifier. The piping was certified as safe for patient use. Based on the evidence, we did not substantiate the allegation and made no recommendations. *(Healthcare Inspection – Medical Oxygen System at the VA Medical and Regional Office Center Wilmington, Delaware, 03-00052-74, 3/18/03)*

Healthcare Inspections Consultations

During the reporting period, OHI inspectors provided consultation to the Office of Investigations staff on 15 criminal investigations; 3 cases required intensive medical record reviews and interviews with witnesses.

OFFICE OF MANAGEMENT AND 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 five divisions:

I. Hotline – The Division determines action to be taken on allegations received by the OIG Hotline. The Division receives thousands of contacts annually from veterans, VA employees, and Congress. The work includes controlling and referring many cases to the OIG Offices of Investigation, Audit, and Healthcare Inspections, or to impartial VA components for review.

II. Operational Support – The Division does follow up on implementation of OIG report recommendations; Freedom of Information Act/ Privacy Act releases; strategic, operational, and performance planning; and IG reporting requirements and policy development.

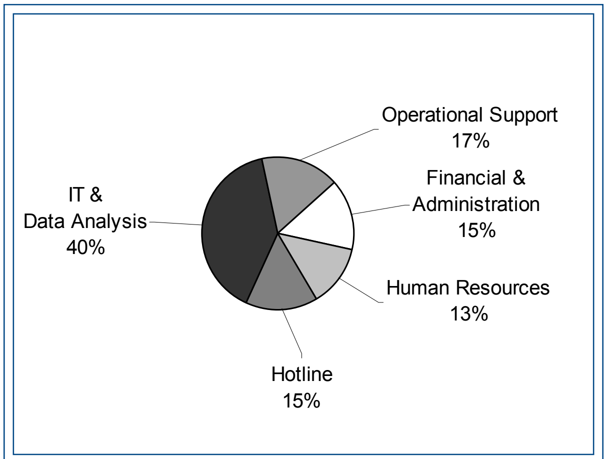
III. Information Technology (IT) and Data Analysis – The Division manages nationwide IT support, systems development and integration; represents the OIG on numerous intra- and inter-agency IT organizations; and does strategic IT planning for all OIG requirements. The Division maintains the Master Case Index (MCI) system, the OIG's primary information system for case management and decision making. The Data Analysis Section, located in Austin, TX, provides data processing support, such as computer matching and data extraction from VA databases.

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

V. Human Resources Management – The Division provides the full range of personnel management services, including classification, staffing, employee relations, training, and incentive awards program.

Resources

The Office of Management and Administration has 57 FTE allocated to the following areas.



I. HOTLINE DIVISION

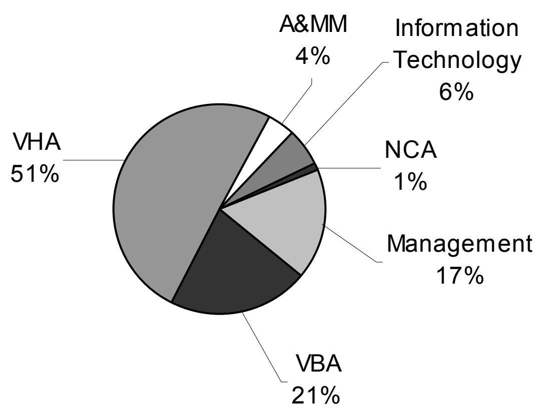
Mission Statement

Ensure that allegations of criminal activity, waste, abuse, and mismanagement are responded to in an efficient and effective manner.

The Division operates a toll-free telephone service, Monday through Friday, from 8:30 AM to 4 PM Eastern Time. Employees, veterans, the general public, Congress, U.S. General Accounting Office, and other Federal agencies report issues of criminal activity, waste, and abuse through calls, letters, faxes, and e-mail messages. Hotline carefully considers all complaints and allegations; OIG or other Departmental staff address mission-related issues.

Resources

The Hotline Division has eight FTE. The following chart shows the estimated percentage of resources devoted to various program areas.



Overall Performance

During the reporting period, the Hotline received 7,534 contacts, which resulted in opening 605 cases. The OIG reviewed 155 (approximately 25 percent) of these and the remaining 450 cases were referred to VA program offices for review.

Output

During the reporting period, Hotline staff closed 657 cases, of which 195 (30 percent) contained substantiated allegations. The Hotline staff wrote 157 letters responding to inquiries received from members of the Senate and House of Representatives.

Outcome

VA managers imposed 45 administrative sanctions against employees and took 68 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled almost $1.2 million.

"Just a note to express my appreciation to the VA OIG staff, and for the hearing aids I recently received." Citing that he was an IG at an Army headquarters during the latter stages of his military career, the veteran stated he was "happy to see the 'IG channels' are still functional."

A Retired U.S. Army Officer

Hotline Special Accomplishment

On March 5, 2003, the Secretary of Veterans Affairs issued VA Directive 0701, titled "Office of Inspector General Hotline Complaint Referrals," which provides updated instructions on how VA officials must respond to OIG Hotline referrals, as well as current information on how employees may contact the Hotline.

Veterans Health Administration

Quality of Patient Care

The responses to Hotline inquiries by VA management officials indicated that 43 allegations regarding deficiencies in the quality of patient care provided by individual facilities had merit and required corrective action. Examples of the issues follow:

- A VHA review found that radiologists failed to properly read a patient's x-rays and missed a diagnosis of cancer. This was due to an increase in the number of radiological tests requested, which resulted in radiologists having to read 20 percent more tests. As a result, two full-time radiologists will join the staff in the summer of 2003. Also, a computerized program has been developed to track the work habits and productivity of the radiologists.

- A VHA review substantiated a care provider failed to follow established hand-washing techniques in the performance of his patient examinations. The provider has been counseled on proper infection control standards. Management has implemented mandatory hand-washing and isolation precaution training for health care workers, along with proper hand-washing techniques as a component of patient education.

- A VAMC review determined that a physician's order for a 2-month follow up appointment on a diabetic heart patient was delayed for 7 months. Management corrected the error. The patient advocate provided her business card to the complainant and his wife for any assistance they may need in the future.

- A VHA review of a veteran's medical file indicated inconsistent documentation relating to the protocol and care of a pressure ulcer. The nurse manager on the medical unit scheduled re-training on skin care protocol for nursing unit personnel.

- A VHA review found that a veteran's counseling session was not conducted in a professional manner. The session was marred by frequent interruptions and the physician paid more attention to the computer rather than to the veteran. Management counseled the physician and is instituting performance measures to ensure quality service is provided to all veterans.

- A VHA review determined that a contract facility failed to provide a veteran with timely initial and follow up care. The parent facility is aware of similar complaints and as a consequence they are in the process of opening a new clinic.

- A VHA review found a nursing aide required additional training and supervision in order to provide care to elderly patients. The employee was found to require supervision and constant reminders of proper patient care techniques and appropriate bedside manner. Management will provide additional in-service training and supervision of the employee in an effort to improve her skills.

Eligibility Controls

The responses to Hotline inquiries by management officials indicate that 7 allegations involving eligibility improprieties or problems with services at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow.

- A VHA review substantiated the allegation that two veterans received medical care for which they were ineligible; the value of this care was approximately $450,000. Management contacted the two veterans and informed them that they would need to transition to some other type of medical coverage, since the medical center will no longer provide medical care to them. The facility will review the eligibility of all current veterans using the medical care system.

- A VHA review determined that VA erred in denying payment of medical bills incurred by a veteran when he sought non-VA emergency care for dangerously high blood pressure. The VAMC telephone triage unit had instructed the veteran to go directly to the emergency room nearest his home. VAMC management has assumed responsibility for medical bills of $18,401.

Employee Misconduct

The responses to Hotline inquiries by management officials indicated that 15 allegations of employee misconduct at individual VA facilities had merit and required corrective action. Examples of the issues follow.

- A review by the Deputy Assistant Secretary (DAS) for Security and Law Enforcement confirmed an incident in which a VAMC police officer drew and displayed his service weapon during the course of a casual conversation. The review determined the VAMC was moving to issue a disciplinary removal against the officer when he sought and was given a transfer to another VA facility. The DAS expressed concerns over the failure of the receiving VAMC's police chief to properly notify his Director of this matter. The DAS informed the Director of the results of the investigation. Additionally, the DAS withheld a firearms authorization for the subject officer pending the outcome of a psychological assessment.

- A VISN review determined that a VA canteen chief inappropriately granted a concession contract to a VA employee to operate a personal business out of the canteen. Although the review did not determine the employee coerced her subordinate employees to purchase her product or used official duty hours to sell the product, management counseled the employee, ordered that the employee remove the magnetic company identification from her vehicle when using her designated parking space on VA premises, and cancelled the contract. The VISN will issue a directive clarifying regulations concerning Federal employees conducting personal business on Government property.

- A VHA review substantiated the allegation that an assistant plant manager at a VAMC laundry facility illegally loaned money to his employees charging them 100 percent interest. He then threatened his employees with bodily harm if the loan was not repaid. He also cashed their paychecks, withholding portions of their funds. As a result, management initiated action to remove the plant manager. VA police referred the matter to the local Assistant U.S. Attorney for prosecutorial consideration.

- A VHA review determined that an employee failed to cooperate with a police officer in an investigation. The review also found the employee improperly purchased non-approved hospital items in excessive amounts and failed to return Government property improperly removed from hospital grounds. Management proposed a 30-day suspension.

Time and Attendance

The responses to Hotline inquiries by management officials indicate that 8 allegations of time and attendance abuse at individual VA facilities had merit and required corrective action. Examples of the issues follow.

- A VHA review substantiated an allegation of time and attendance abuse. A recreation therapist/timekeeper failed to record the time she and another therapist worked. The supervisor permitted this flexible scheduling without appropriate documentation. Management will initiate appropriate disciplinary action against the timekeeper and provide written counseling and training to all involved in the abuse.

- A VHA review found that an allegation of time and attendance irregularities was substantiated. As a result, corrective action was taken to have the employee adhere to her established tour of duty. Also, the employee's supervisor is now maintaining a permanent record of the dates and times that the employee leaves the department on union business.

Fiscal Controls

The responses to Hotline inquiries by management officials indicate that 5 allegations of deficient or improper fiscal controls at individual VA facilities had merit and required corrective action. An example follows:

- A VHA review confirmed that a medical center failed to process fee-basis payments in a timely manner. Some delinquent payments were over 90 days old. Management directed staff to pay all delinquent claims and to refocus their efforts to prevent a recurrence of delays in payments. Additionally, the medical center contacted the provider to restore a good working relationship.

Patient Safety

The responses to Hotline inquiries by management officials indicate that 9 allegations of patient safety deficiencies at individual VA facilities and at a state veterans home had merit and required corrective action. Examples of the issues follow:

- A VAMC review determined that two mental health professionals used poor judgment when they permitted a patient, who had already admitted to ingesting a large quantity of narcotic medication, to return to the domiciliary unescorted. While she was unsupervised, the patient obtained and ingested more drugs and had to be taken to a community hospital for further treatment. Management is in process of disciplining the social worker and the psychologist.

- A VHA review substantiated the allegation that a quadriplegic patient and a paraplegic patient engaged in an altercation that led to the paraplegic repeatedly pushing his gurney into the quadriplegic's bed and threatening him. The nurse manager counseled the paraplegic and moved him to another room to preclude further encounters.

- A state veterans home social service department review substantiated the allegation of patient abuse at a state veterans home. The review found that a patient was attacked on several occasions by his roommate, who was diagnosed with schizophrenia and dementia. Management transferred the roommate to a locked unit.

Government Equipment and Supplies

The responses to Hotline inquiries by management officials indicate that 8 allegations involving misuse of Government equipment and supplies at individual VA facilities had merit and required corrective action. An example follows:

- A VHA review substantiated an employee misused his VA computer and telephone access to repeatedly contact various travel sites in support of outside employment as a travel agent. Management proposed removal of the employee.

Personnel Issues

The responses to Hotline inquiries by management officials indicate that 8 allegations involving improprieties in the personnel practices at individual VA facilities had merit and required corrective action. Examples of the issues follow:

- A VAMC review determined a vacancy announcement posted on a VA website contained factual errors including authorization of relocation expenses and an incorrect locality pay rate. The review noted that the successful candidate was advised of the changes at the time he was offered the job, which he then accepted. Management reminded personnel specialists to ensure all vacancy announcements reflect accurate information.

- A VHA review determined that an employee and her supervisor were engaged in a non-professional relationship. The supervisor allowed the employee to frequently report late and leave work early, without charge to annual leave. A second supervisor hired his wife's nephew to fill a temporary position that was later converted to permanent. Due to the number of relatives hired at the medical center, management counseled the supervisors involved and took appropriate disciplinary action. Supervisors involved in the selection and hiring process at the facility have also received appropriate training.

Ethical Improprieties

The responses to Hotline inquiries by management officials indicate that 3 allegations involving violations of ethical conduct standards at individual VA facilities had merit and required corrective action. An example of the issue follows.

- A VHA review found an employee engaged in an improper personal and financial relationship with a patient. The review proposed termination; however, final action is being held in abeyance pending consultations between human resources and the union. Additionally, all personnel will receive refresher ethics training specific to relationships and financial transactions between staff and patients.

Privacy Issues

The responses to Hotline inquiries by management officials indicate that 8 allegations involving Privacy Act violations at individual VA facilities had merit and required corrective action. Examples of the issues follow.

- A VHA review substantiated a senior official released sensitive information regarding a veteran to a third party without the veteran's authorization. A letter of reprimand has been issued by management and will be placed in the employee's file. Management issued a letter of reprimand to the senior official.

- A VAMC review verified a VA employee accessed a veteran's medical records 38 times in a 4-year period. During this period of time, the employee and the veteran were involved in a personal relationship and the employee had no official reason to access the records. Management disciplined the employee and will continue to monitor access to this veteran's records.

Facilities and Services

The responses to Hotline inquiries by VA management officials indicated that 28 allegations regarding deficiencies with facilities or the services provided by individual VA facilities had merit and required corrective action. Examples of the issues follow.

- A VHA review concluded that a clinic's lack of a computer and terminal linkage to the parent medical facility hindered the physician's ability to provide continuity of care and timely forwarding of prescriptions to the pharmacy. As a result, the clinic is now equipped with a computer and terminal to enable immediate access to the parent facility during appointments.

- A VHA review substantiated allegations of system problems that resulted in a patient's untimely receipt of heart medication refills. The review also found that a clinical coordinator failed to respond to the patient's concerns thus causing the prescription to expire. Management provided the patient an immediate 14-day supply of the medication through a local pharmacy. The clinical coordinator was counseled on her failure to assist the patient with his concerns.

- A VHA review confirmed problems with a medical center's telephone and voicemail system, as well as lapses in courtesy. Management is reviewing the telephone system to determine a more appropriate way to meet the needs of its customers.

Additionally, management incorporated comments from the veteran's family into the mandatory employee customer service training program.

- A VHA review concluded that an eligibility clerk threatened a veteran with denial of medical care if he did not fill out new forms and enrollment data after he transferred between medical centers. Management informed the eligibility clerk that the veteran's computer file could have been requested from the losing medical center and new enrollment forms were not necessary. Arrangements were made with the veteran for continued medical care.

Veterans Benefits Administration

Receipt of VA Benefits

The responses to Hotline inquiries by management officials indicate that 22 allegations involving improprieties in the receipt of VA benefits had merit and required corrective action. Examples of the issues follow.

- A VBA review concluded a veteran's benefits should be reduced from 60 to 40 percent service connection as a result of his reexamination. The veteran's individual unemployability benefits were terminated, avoiding erroneous payments estimated at more than $625,000.

- A VBA review substantiated the allegation that an incarcerated veteran continued to receive his VA benefits. The VARO notified the veteran that his benefits will be suspended, creating an overpayment of $12,043.

- A VBA review substantiated the allegation that a veteran collecting an income-based pension from VA failed to report his marriage or his wife's substantial income. As a result, VBA created an overpayment of $10,285.

- A VBA review revealed that a veteran's son and fiduciary misappropriated $8,470 of his VA benefits. Management worked out a payment plan with the fiduciary at a rate of $240 per month.

Facilities and Services

The responses to Hotline inquiries by management officials indicate that 22 allegations regarding deficiencies with facilities or the services provided by individual VA facilities had merit and required corrective action. Examples of the issues follow.

- A VBA review substantiated the allegation that a series of administrative errors and assumptions on the part of VA employees erroneously held a widow of a VA beneficiary responsible for a VA-backed mortgage loan. Additionally, the review found an employee might have been discourteous to a family member attempting to resolve the situation. Management corrected the VA records and counseled the employees.

- A VBA review confirmed that a veteran's identification data contained a Social Security number and date of birth that matched the profile of a deceased veteran; however, other data was correct. VBA initiated an inquiry with the Social Security Administration that supported the veteran's claim of erroneous data entry by a prior VARO. The veteran's current VARO made the appropriate correction and established a claim for educational benefits.

Fiscal Controls

- A VBA review substantiated that an educational institution had summarily cancelled classes prior to filing for bankruptcy protection 4 weeks later. At the time, three veterans were enrolled through a VARO vocational rehabilitation program, one whose tuition had already been paid. All three veterans have been placed in new programs, and the regional counsel will file a claim through the court to recover the tuition.

National Cemetery Administration

Receipt of Benefits

- An administrative review found that funeral home sales consultant might have contacted a veteran, asking him to send $35 and a copy of his military discharge certificate to preregister for interment at a VA cemetery projected to open in Palm Beach, Florida, in 2007. NCA prepared an outreach campaign, targeted to news outlets and veterans service organizations in Florida. The campaign told how to arrange for national cemetery burial, and alerted veterans to be cautious of private individuals who contact them about veterans burial benefits, especially if money is requested for a service. This case resulted in a VA Office of Public Affairs news release, with input from NCA and OIG, to local Florida newspapers and media.

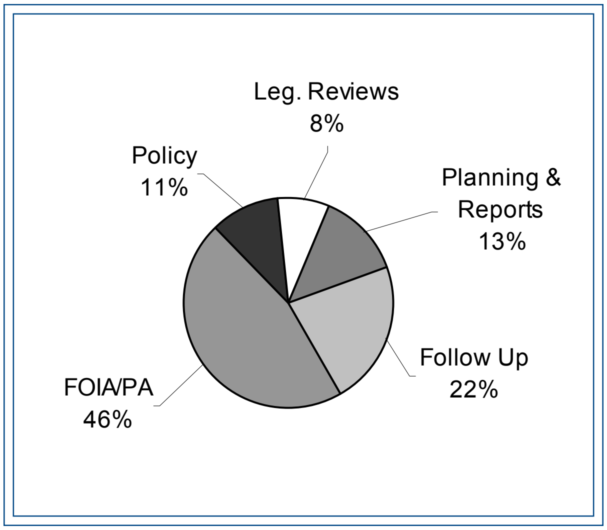
II. OPERATIONAL SUPPORT DIVISION

Mission Statement

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

Resources

This Division has nine FTE assigned with the following allocation.



Overall Performance

Follow Up on OIG Reports

Operational Support is responsible for obtaining implementation actions on previously issued audits, inspections, and reviews with over $1 billion of actual or potential monetary benefits as of March 31, 2003.

The Division is also responsible for maintaining the centralized follow up 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 promptly and that corrective actions are implemented, as agreed by VA management officials. VA's Deputy Secretary, as the Department's audit resolution official, resolves any disagreements about recommendations.

After obtaining information that showed management officials had fully implemented corrective actions, Operational Support closed 72 reports and 437 recommendations with a monetary benefit of $18 million during this period. As of March 31, 2003, VA had 65 open OIG reports with 221 unimplemented recommendations.

Freedom of Information Act, Privacy Act, and Other Disclosure Activities

Operational Support processes all OIG FOIA and PA requests from Congress, veterans, veterans service organizations, VA employees, news media, law firms, contractors, complainants, the general public, and subjects of investigations. In addition, we processed 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. Operational Support also processed OIG reports and documents to assist VA management in establishing evidence files used to support administrative or disciplinary actions against VA employees.

During this reporting period, we processed 215 requests under the FOIA and PA and released 280 audit, investigative, and other OIG reports. Information was totally denied in 24 requests and partially withheld in 120 requests, because release would constitute an unwarranted invasion of personal privacy, interfere with enforcement proceedings, disclose the identity of confidential sources, disclose internal Departmental matters, or was specifically exempt from disclosure by statute. During this period, all FOIA cases received a written response within 20 workdays, as required. There are no cases pending over 6 months.

Review and Impact of Legislation and Regulations

Operational Support coordinated concurrences on 39 legislative, 48 regulatory, and 79 administrative proposals from the Congress, OMB, and VA. The OIG commented and made recommendations concerning the impact of the legislation and regulations on economy and efficiency in the administration of programs and operations or the prevention and detection of fraud and abuse.

III. INFORMATION TECHNOLOGY AND DATA ANALYSIS DIVISION

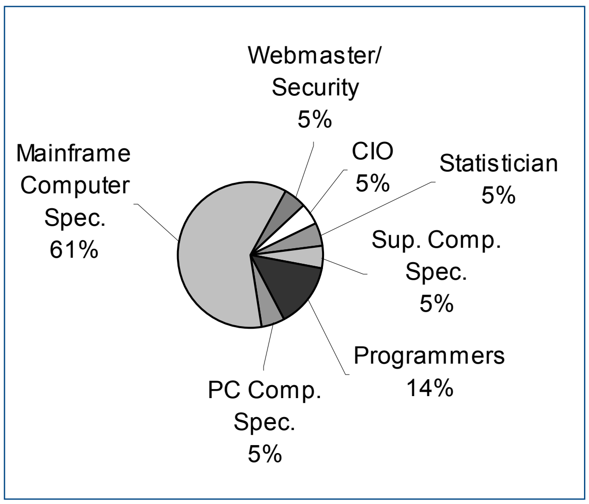
Mission Statement

> ***Promote OIG organizational effectiveness and efficiency by ensuring the accessibility, usability, and security of OIG information assets; developing, maintaining, and enhancing the enterprise database application; facilitating reliable, secure, responsive, and cost-effective access to this database, VA databases, and electronic mail by all authorized OIG employees; providing Internet document management and control; and providing statistical consultation and support to all OIG components. Provide automated data processing technical support to all elements of the OIG and other Federal Government agencies needing information from VA files.***

The Information Technology and Data Analysis 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, guarantee uninterrupted access to electronic mail, service personal computers, detect and defeat computer threats, and provide support in protecting all electronic communications. The OIG's Chief Information Officer and staff represent the OIG on numerous intra- and inter-agency IT organizations and are responsible for strategic IT planning for all OIG requirements. The Data Analysis Section in Austin, TX provides data gathering and analysis support to employees of the OIG, as well as VA and other Federal agencies, requesting information contained in VA automated systems. Finally, a member of the staff serves as the OIG statistician.

Resources

The Division has 22 FTE allocated in Washington, Austin, and Chicago. These FTE are devoted to the following areas.



Overall Performance

Master Case Index (MCI)

During this reporting period, we provided the OIG field personnel with more than 50 enhancements of the MCI, the OIG's enterprise database. Most notably, the Division implemented MCI modules to track the fugitive felon match, as well as allocations in travel, training, and supplies. It also implemented a significantly more robust assigned weapons tracking system for the Office of Investigations.

We successfully migrated a portion of the functionality and data in MCI from the current client-server environment to a "web-enabled" *Oracle 9i* production database. We initiated testing an application for Hotline using *Oracle 9i* tools that will allow users to store online all source material from complainants and all documents referred to VA management for resolution.

Internet and Electronic Freedom of Information Act

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. Data files on the OIG website were accessed over 964,000 times by more than 159,000 visitors. The most popular reports were downloaded over 84,000 times, providing both timely access to OIG customers and cost avoidance in the reduced number of reports printed and mailed. OIG vacancy announcements accounted for an additional 4,400 downloads.

We posted the frequently-requested Investigations report "Summary of the Philippines Benefit Review" in our electronic reading room in compliance with the Electronic Freedom of Information Act. We posted 16 other CAP and audit reports, Office of Investigations press releases, and other OIG publications, including this semiannual report to Congress, on the OIG website.

Information Management, Security, and Coordination

We participated in the development of Departmental policy and programs to improve VA information security, IT accessibility, and Internet resources and utilization. We provided review and feedback on problems with VA draft policy including media sanitation policy; information security officer professionalization and certification initiatives; privacy program; personnel security; classified information handling; and the proposed cyber security reviews, inspections, and assessments program.

Statistical Support

The OIG statistician is part of the technical support team under the direction of the OIG's Chief Information Officer and provides assistance in planning, designing, and sampling for relevant OIG projects. In addition, the statistician provides support in the implementation of appropriate methods to ensure that data collection, preparation, analysis, and reporting are accurate and valid.

For the reporting period, the OIG statistician provided statistical consultation and support on six research design and/or sampling plans for proposed audit projects and OHI proactive program evaluations, statistical support for all CAP reviews, and data concerning purchase card use at each facility.

Information Technology Training Initiative

We contracted with four vendors to provide instructor-led training in a variety of *Microsoft* applications in the classroom in our Washington, DC, headquarters office and one vendor with training facilities in each city in which the OIG is located to provide training for our field employees. To date, 144 employees have received 445 days of instructor-led training in Washington, DC, while 98 field employees have received 238 days of training locally.

DATA ANALYSIS SECTION

The Data Analysis Section (DAS) develops proactive computer profiles that search VA computer data for patterns of inconsistent or irregular records with a high potential for fraud and refers these leads to OIG auditors and investigators for further review. The DAS provides technical assessments and support to all elements of the OIG and other governmental agencies needing information from VA computer files. Significant efforts include the following.

Biohazard Review

The mailing of anthrax by suspected terrorists prompted a national review of biological, chemical, and radioactive agents purchased by Government laboratories. The DAS assisted in this review by focusing on more than 60,000 transactions related to purchases of these substances at 28 VA facilities. Many of these agents and organisms were purchased under a variety of clinical and generic names that varied from vendor to vendor. The DAS found several additional vendors previously unidentified and identified 30 different types of these agents purchased from more than 12 primary commercial suppliers.

Fugitive Felon Matches

In compliance with recently signed legislation authorizing a computer match of VA records to state and Federal files, the DAS matched more than 700,000 felony warrant files from the National Crime Information Center, the California Department of Justice, and the U.S. Marshals Service to more than 16 million records contained in VA benefit system files. We identified more than 10,000 matches.

Data Mining to Detect Potential Fraud in VA Computer Systems

The DAS took a proactive approach to finding and reporting fraud by developing computer profiles that reflect the procedures used to defraud the VA. As a result of these data mining efforts, we referred 24 cases of potential fraud to OIG investigators for further review. The cases included: suspected deceased payees still receiving VA benefit payments, questionable payments to suspicious addresses, payments to incarcerated veterans, and educational payments to potentially bogus veterans and schools.

VA Drug Treatment Program Reporting

Each year VA uses past workload, such as that published by the VA Program Evaluation and Resource Center, to measure the success of VA drug treatment programs in budgetary calculations. To support the attestation to the correctness of these reports by OIG auditors, the DAS conducted an extensive analysis on a series of 34 computer programs to verify data reported. This review indicated that VHA's Office of National Drug Counseling Programs is likely underreporting their workload.

VA Workers Compensation Program Costs

The DAS assisted OIG auditors in their review of workers' compensation claims and related costs to determine if problems identified in a 1998 audit were corrected. The DAS received a file of over 7,000 active claims from the U.S. Department of Labor. From this file, the DAS identified 84 persons receiving VA compensation and pension benefits in addition to workers' compensation benefits, and over 2,500 claimants who were never employed by VA or may have died since the last audit review.

Combined Assessment Program Reviews

The DAS provided technical support and data to 20 CAP heath care reviews focusing on the quality, efficiency, and effectiveness of medical services provided to veterans. The DAS also provided support to six CAP reviews on VA benefits, which focused on the delivery of monetary benefits to veterans and their dependents.

Preaward and Postaward Contract Reviews

The DAS provided technical support and data to six preaward and postaward contract reviews conducted by the OIG to identify better prices to VA and disclose overcharges by private sector contractors.

Assistance to Other Agencies

The DAS provided assistance to six Federal agencies for information contained in VA computer files. Agencies included the Department of Defense, Department of Energy, Department of Justice, U. S. Postal Service, U.S. Marshals Service, and FBI.

Other Workload

During the reporting period, the DAS completed 105 ad hoc requests for data requested by all other OIG operational elements. Considerable effort was also expended by DAS in support of an on-site review of physicians' attendance and associated intern oversight, a benefits payments integrity audit, and potential kickbacks to a physician from recipients of large retroactive compensation payments.

IV. FINANCIAL AND ADMINISTRATIVE SUPPORT DIVISION

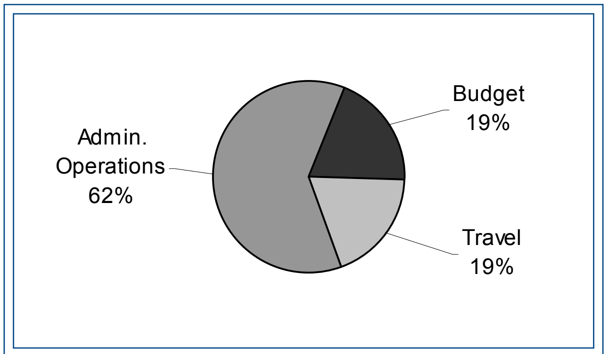
Mission Statement

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

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

Resources

Eight staff currently spend time across three functional areas in the following proportions.



Overall Performance

Budget

The staff assisted in the preparation of the FY 2004 budget submission and materials for associated hearings with VA, OMB, and the Congress. During the year to date, we prepared eight budget operating plans to support the continuing resolutions enacted before the final appropriations legislation for FY 2003.

Travel

By the nature of our work, OIG personnel travel almost continuously. As a result, we processed 1,218 travel, 47 permanent change of station vouchers, and 30 amendments to existing authorities.

Administrative Operations

The administrative staff works closely with VA Central Office administrative offices and building management to coordinate various administrative functions, office renovation plans, telephone installations, and the procurement of furniture and equipment.

In addition, we processed 143 procurement actions and each month reviewed and approved the 24 statements received from the OIG's cardholders under the Government's purchase card program.

V. HUMAN RESOURCES MANAGEMENT DIVISION

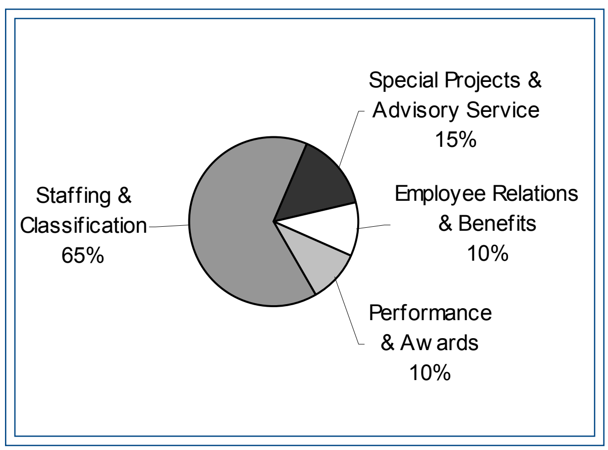
Mission Statement

> ***Promote OIG organizational effectiveness and efficiency by providing reliable and timely human resources management and related support services.***

The Division provides human resources management services for the entire OIG. These services include internal and external staffing, classification, pay administration, employee relations, benefits, performance and awards, and management advisory assistance. It also serves as liaison to the VA Central Offices of Human Resources and Payroll, as those offices process our actions into the VA integrated payroll and personnel system.

Resources

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



Overall Performance

Human Resources Management

During this period, the staff brought 13 new employees on board; there were 26 losses. During much of the reporting period, we were under a continuing resolution, and many recruitment actions were on hold. In addition, the staff processed 93 personnel actions and 31 awards and provided support to accomplish the Federal Activities Inventory Act reporting requirements.

The OIG Executive Development Program was announced in February 2003 to identify OIG employees with demonstrated leadership potential and develop a pool of qualified individuals for Senior Exeutive Service positions.

In March 2003, we initiated a Telework Program designed to promote employee workplace flexibility consistent with efficient operations and mission accomplishment of the OIG. In addition to reducing traffic congestion and environmental pollution, it is aimed at increasing employee recruiting, retention, and morale that can result from alternative workplace programs.

OTHER SIGNIFICANT OIG ACTIVITIES

President's Council on Integrity and Efficiency

- The VA OIG hosted the annual retreat for all Federal IGs from March 24-26, 2003. It was held in St. Michaels, Maryland, and 52 of 61 Inspectors General attended or were represented.

- The OIG Audit Planning Division staff continues to participate in the PCIE workgroup on improper and erroneous payments. This workgroup is addressing the definition of an improper payment, identifying the challenges and root causes of improper payments, and preparing Government-wide guidance to help reduce improper payments.

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

OIG Management Presentations

Leadership VA 2002 Program

The Inspector General made a presentation on the work of the OIG to the Leadership VA Class of 2002. This program is VA's premier leadership development program.

Office of Acquisition and Materiel Management's Acquisition Forums

The Counselor to the IG and an OIG representative from the Contract Review and Evaluation Division made a presentation to VA contracting personnel working at local medical facilities. The presentation covered various aspects of contracting with affiliates for health care resources.

National Acquisition Center Pharmaceutical Conference

A representative from the Contract Review and Evaluation Division made a presentation on "How to Prepare for a Preaward Review" to FSS pharmaceutical industry representatives.

Washington, DC, Metropolitan Chapter of Certified Fraud Examiners

An audit manager from the OIG Central Office Operations Division made a presentation on electronic scanning for network vulnerabilities at a meeting of the certified fraud examiners.

Pain Management Society

A healthcare inspector from the Atlanta Healthcare Regional Office presented an abstract and information on the OIG pain management initiative to members of the Pain Management Society during their annual conference held in Chicago.

Awards

PCIE Fifth Annual Awards Ceremony - October 30, 2002

- Three staff members from the Seattle Audit Operations Division received an "Award for Excellence - Audit" in recognition of outstanding results achieved in a series of audits of VA supply inventory management practices. These audits resulted in $370 million in monetary benefits and led to significant improvements in the management of supply inventories at VA medical facilities. The VA supply inventory management team consisted of David Sumrall, Jay Johnson, and Kent Wrathall.

- Eight staff members from the Kansas City Audit Operations Division received an "Award for Excellence - Audit" in recognition of their efforts in auditing VA's Medical Care Collection Fund program. The audit identified opportunities for VA to increase collections by about $504 million. The team consisted of William Withrow, Robert Zabel, Joseph Janasz, Ken Myers, Carla Reid, Oscar Williams, Dennis Capps, and Henry Mendala.

- Ten staff members from the Office of Investigations, Office of Audit, and Office of Management and Administration received an "Award for Excellence - Investigations" as part of an interdisciplinary team whose hard work contributed significantly to the successful investigation and prosecution of the twelve individuals who perpetrated the largest fraud scheme in the history of VA. A total of $11.2 million was embezzled from VA. The embezzlement investigative team consisted of Darlene Perkins, Danny Penton, Yolanda Johnson, Marcia Drawdy, Roy Nicholson, George Patton, Deanna Moczygemba, Trudy Pickle, Connie Meyer, and Linda Knop.

- Eleven staff members from the Office of Healthcare Inspections received an "Award for Excellence - Evaluations" in recognition of their review of VHA's patient safety program that identified ways to improve controls for ensuring the safety of vulnerable patients who are at risk of wandering or walking away from VHA medical facilities. The team consisted of Victoria Coates, Nelson Miranda, Daisy Aruguy, Linda DeLong, John Rowland, Bertha Clarke, Paula Chapman, Katherine Owens, Jim Marchand, Marisa Casado, and Christa Sisterhen.

- Eighteen staff members from the Office of Investigation, Office of Audit, Office of Healthcare Inspections, and Office of Management and Administration received an "Award for Excellence - Multiple Disciplines" in recognition for their outstanding performance in recovering approximately $25 million in cost savings to VA while conducting a benefits review in the Philippines. The team consisted of James Gaughran, Michael Seitler, William Withrow, Debra Crawford, Dean Wauson, Darlene Perkins, David Spilker, Peter Moore, Marcia Drawdy, Manual Mireles, Russell Lewis, Daisy Arugay, Ronald Baker, Diane Banduch, James Price, Robert Ball, Jack Robinson, and Brenda Uptain.

- Thirty-one staff members from the Office of Healthcare Inspections and Office of Audit received an "Award for Excellence - Multiple Disciplines" for their review of VA owned or controlled biological agents, chemicals, and radioactive materials that have the potential for use as weapons of mass destruction. Reviewers identified controls that needed improvement to strengthen security, access, inventory, and oversight requirements and procedures for safeguarding all high-risk or sensitive materials or agents in VHA facilities. The team consisted of Jim Marchand, Sheila Cooley, Beth MacLean, Linda DeLong, Marion Slachta, Verena Briley-Hudson, Patricia Conliss, Pat Christ, Katherine Owens, Edna Thomas, Linda Halliday, Julie Watrous, Lynn Scheffner, Daisy Arugay, Shoichi Nakamura, Wilma Wong, Janet Mah, Nelson Miranda, Alvin Wiggins, Paula Chapman, John Tryboski, Manuel Mirales, Victoria Coates, Jacqueline Strumbris, Rayna Nadal, Leslie Rogers, Vishala Sridhar, William Bailey, Orlando Vasquez, Christa Sisterhen, and Elizabeth Bullock.

- Thirteen DAS employees received an "Award for Excellence - Management" for their efforts in providing data mining and analytical support of several high profile projects including the work done in support of the national review of one-time payments at 57 VAROs. Team members included Roger Perez, Jerry Goss, Kathleen Johnson, Mary Lopez, Deanna Moczygemba, Trudy Pickle, Celeste Weeks, Emil Balusek, Scott Harris, Francine Kimbrell, Gilberto Melendez, Roy Nicholson, and Brenda Uptain.

- Eight staff members from the OIG Hotline Division received an "Award for Excellence - Management" in recognition of the outstanding performance of the Hotline team in providing exceptional support to VA and the OIG community. Team members included Linda Greco, Emily Junipher, Michael Kirby, Christina Lavine, Diane McCray, Clifford Phillips, Dorcas Smith, and Joseph Vallowe.

- The PCIE presented an "Award for Excellence - Response to September 11 Attack" in special recognition of the OIG community for their unprecedented efforts in responding to the attack on the United States that occurred on September 11, 2001, and protecting the citizens of the United States from further attack. The following members of the VA OIG received the award for service to their country on that fateful day and the months following the attack: Bruce Sackman, John McDermott, Gregg McLaughlin, Jenny Pate, Chris Wagner, Rubin Jackson, Thomas Valery, Jeffrey Hughes, Samantha Lockery, Curt Vincent, and Marl Lazarowitz.

Uniformed Health Services Award

The Department of Medicine, Uniformed Services, University of Health Sciences, in Washington, DC, presented the "James J. Leonard Award for Excellence in Teaching Internal Medicine" to Dr. George Wesley in March 2003. Students and peers recognized Dr. Wesley, OHI's Medical Officer and Consultant to the IG, for his professionalism and vital contributions to the success of the Uniformed Services University clinical training program.

APPENDIX A

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM REVIEWS				
02-01933-3 10/16/02	Combined Assessment Program Review of the VA Medical Center Lexington, KY	$1,650,000	$1,650,000	
02-01760-6 10/18/02	Combined Assessment Program Review of the Bronx VA Medical Center Bronx, NY			$17,326
02-00868-15 11/13/02	Combined Assessment Program Review of the VA Medical Center San Juan, PR	$1,438,600	$1,438,600	$36,600
02-01811-28 12/10/02	Summary Report of Combined Assessment Program Reviews at the Veterans Health Administration Medical Facilities April 2001 through September 2002			
02-02248-31 12/13/02	Combined Assessment Program Review of the VA Regional Office Nashville, TN			
02-02582-36 12/20/02	Combined Assessment Program Review of the VA Medical Center Boise, ID	$1,438,600	$1,438,600	
02-01811-38 12/23/02	Summary Report of Combined Assessment Program Reviews at the Veterans Benefits Administration Regional Offices June 2000 through September 2002			
02-01432-39 12/24/02	Combined Assessment Program Review of the VA Medical Center Birmingham, AL	$115,000	$115,000	
01-02641-4 12/26/02	Combined Assessment Program Review of the Northern Arizona VA Health Care System Prescott, AZ			
02-01430-50 1/23/03	Combined Assessment Program Review of the Chalmers P. Wylie VA Outpatient Clinic Columbus, OH			
03-01091-51 1/29/03	Summary Report of Combined Assessment Program Reviews at the Veterans Health Administration Medical Facilities, October 2002 through December 2002			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM REVIEWS (Cont'd)				
02-01273-55 2/3/03	Combined Assessment Program Review of the VA Medical Center West Palm Beach, FL			$19,807
02-02757-63 2/25/03	Combined Assessment Program Review of the VA Medical Center Atlanta, GA			
02-03263-68 3/7/03	Combined Assessment Program Review of the VA Salt Lake City Health Care System			
02-01985-77 3/26/03	Combined Assessment Program Review of the VA Medical Center Alexandria, LA			
JOINT REVIEW				
01-00679-29 12/30/02	Summary of the Philippines Benefit Review			
INTERNAL AUDITS				
01-02719-27 12/4/02	Audit of the Department of Veterans Affairs Information Security Program			
02-01638-47 1/22/03	Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2002 and 2001			
02-02245-64 2/28/03	Report of the Audit of the Department of Veterans Affairs' Franchise Fund Consolidated Financial Statements for Fiscal Year 2002			
OTHER OFFICE OF AUDIT REVIEWS				
02-00198-4 10/15/02	Report on Promptness of Department of Veterans Affairs' Payments to the District of Columbia Water and Sewer Authority for the 6 Months Ending September 30, 2002			
02-01009-30 12/16/02	Evaluation of Allegations of Mismanagement in Information Resources Management Service at the VA Chicago Health Care System Chicago, IL	$41,931	$41,931	
01-01613-52 2/6/03	Accuracy of VA Data Used to Compute the Rehabilitation Rate for Fiscal Year 2000			
02-02856-76 3/20/03	Evaluation of Alleged Government Purchase Card Misuse and Conflicts of Interest in Facilities Management Service at the VA San Diego Healthcare System			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
OTHER OFFICE OF AUDIT REVIEWS (Cont'd)				
02-01481-78 3/31/03	Evaluation of Selected VA Procurement and Small Business Program Issues			
CONTRACT REVIEWS *				
02-02156-9 10/22/02	Verification of Novartis Pharmaceuticals Corporation's Self-Audit Under Federal Supply Schedule Contract Number V797P-5354x			$93,819
02-01701-10 10/24/02	Review of Federal Supply Schedule Proposal Submitted by Remel Inc. Under Solicitation Number M5-Q52D-01	$5,467,620		
02-02935-12 11/4/02	Review of Proposal Submitted by Stanford University, Under Solicitation Number RFP 261-0206-02, for Oral and Maxillofacial Surgery Services at the Department of Veterans Affairs Medical Center Palo Alto, CA			
02-02688-16 11/6/02	Review of Proposal Submitted by University of Cincinnati Department of Radiology Under Solicitation Number 539-11-02 for Outsourced Referral Imaging Services for the Department of Veterans Affairs Medical Center Cincinnati, OH			
02-02934-17 11/6/02	Review of Proposal Submitted by the University of California, San Francisco, Under Solicitation Number RFP 261-0178-02, for Radiology Physicians Services at the Department of Veterans Affairs Medical Center San Francisco, CA	$509		
02-02554-18 11/7/02	Review of Proposal Submitted by Stanford University, Under Solicitation Number RFP 261-0320-01, for Chief of Surgery and Cardiothoracic Surgery Services at the Department of Veterans Affairs Medical Center Palo Alto, CA	$749,863		
02-02508-19 11/7/02	Review of Proposal Submitted by University Radiology Associates of Cincinnati, Inc. Under Solicitation Number 539-05-02 for Radiation Therapy (Oncology) Services for the Department of Veterans Affairs Medical Center Cincinnati, OH			
00-02781-22 11/19/02	Settlement Agreement, Indigo Medical, Inc.			$2,144

* 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 recommendations.

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

CONTRACT REVIEWS (Cont'd)

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
98-00110-21 11/20/02	Post-Award Review of Medtronic, Inc's. Federal Supply Schedule Contract Number V797P-3438j			$10,420
02-03163-23 11/20/02	Review of Proposal Submitted by the University of Utah Under Solicitation Number 660-011-02 for Anesthesiology Services at the Department of Veterans Affairs Salt Lake City Health Care System	$418,552		$23,046
02-02687-25 12/2/02	Review of Proposal Submitted by University of Cincinnati, Under Solicitation Number 539-15-02, for On-Site Professional Imaging Services at the Department of Veterans Affairs Medical Center Cincinnati, OH	$1,436,441		
02-02635-26 12/2/02	Review of Proposal Submitted by Stanford University, Under Solicitation Number RFP 261-0057-02, for Neurosurgeon Services at the Department of Veterans Affairs Medical Center Palo Alto, CA	$315,878		
00-02843-42 12/30/02	Review of Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5372x, Awarded to Ortho Biotech, Incorporated			
03-00687-43 12/30/02	Preaward Review of America Health Research Institute's Offer to Provide Mobile MRI Services to the VA Medical Center Alexandria, LA			
00-02845-46 1/15/03	Review of Janssen Pharmaceutica Products, L.P. Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract V797P-5306x			$110
03-00001-48 1/15/03	Review of First Option Year Proposal Submitted by the Medical School of Wisconsin Under Contract Number V69DP-3508, for Radiology Services for the Department of Veterans Affairs Medical Center Milwaukee, WI			
02-03445-49 1/16/03	Review of Proposal Submitted by Stanford University School of Medicine, Department of Urology, Under Solicitation Number 261-0234-02, for Urology Services at the Department of Veterans Affairs Palo Alto Healthcare System			
02-02933-53 2/4/03	Review of Proposal Submitted by the University of California, San Francisco, Under Solicitation Number RFP 261-0028-02, for Radiation Services to the Department of Veterans Affairs Medical Center San Francisco, CA	$406,469		

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

CONTRACT REVIEWS (Cont'd)

03-00687-54 2/4/03	Review of Proposal Submitted by American Health Research Institute, Inc., Under Solicitation Number RFP 502-12-03, for Mobile Magnetic Resonance Imaging Services at the Department of Veterans Affairs Medical Center Alexandria, LA			
03-00559-59 2/18/03	Review of General Electric Medical Systems, Inc.'s Direct Delivery Pricing Proposal for Nuclear Imaging Systems Under Solicitation Number M6-Q7-02			
02-02516-60 2/20/03	Review of Abbott Laboratories, Inc.'s Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5396x			$9,505
02-02071-61 2/24/03	Verification of Bracco Diagnostics, Inc.'s Self-Audit of Federal Supply Schedule Contract Number V797P-5261x			$38,990
02-03435-62 2/27/03	Review of Federal Supply Schedule Proposal Submitted by KCI USA Under Solicitation Number RFP-797-FSS-99-0025-R2	$1,289,603		
93-00056-66 3/4/03	Settlement Agreement, Postaward Review of Pharmaceutical Manufacturer			$5,000,000
99-00120-65 3/5/03	Settlement Agreement, Postaward Review of Medical Supply Manufacturer			$10,500,000
03-00818-67 3/5/03	Review of Proposal Submitted by the Medical College of Virginia Physicians Under Solicitation Number 652-049-02 for Radiation Oncology Services at VAMC Richmond, VA			
02-02041-69 3/11/03	Review of Federal Supply Schedule Proposal Submitted by Becton, Dickinson & Company Under Solicitation Number RFP-797-FSS-99-0025	$30,458,367		
00-02784-70 3/12/03	Review of Centocor, Inc.'s Analysis of Contract Compliance for Federal Supply Schedule Contract Number V797P-5292x			$12,498
02-01684-73 3/17/03	Review of Voluntary Disclosure of Defective Pricing Submitted by Carepoint Cardiac Corporation dba Spectral USA Under Federal Supply Schedule Contract Number V797P-5444x			$13,924
99-00101-75 3/19/03	Review of Serono Laboratories Inc.'s Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585, Under Federal Supply Schedule Contract Number V797P-5159x			

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

HEALTHCARE INSPECTIONS

Report Number/ Issue Date	Report Title	OIG	Management	Questioned Costs
02-01221-1 10/4/02	Healthcare Inspection, Patient Care Issues Greater Los Angeles Healthcare System Los Angeles, CA			
01-02341-2 10/4/02	Healthcare Inspection, Patient Care and Management Issues at the Department of Veterans Affairs Medical Center San Juan, PR			
02-02177-5 10/10/02	Healthcare Inspection, Infection Control and Patient Care Issues, Harry S. Truman Memorial Veterans Hospital Columbia, MO			
02-02374-8 10/18/02	Healthcare Inspection, Patient Care Issues Department of Veterans Affairs Hudson Valley Health Care System Franklin Delano Roosevelt Campus Montrose, NY			
01-02748-7 10/25/02	Healthcare Inspection, Discharge Planning and Other Patient Care Issues at the VA Northern Indiana Healthcare System			
02-02514-13 11/4/02	Healthcare Inspection and Investigation, Care Provided to a Patient with Hepatitis C, Washington, DC, VA Medical Center			
01-01340-14 11/13/02	Healthcare Inspection, Patient Care and Employee Conduct Issues, VA New Jersey Healthcare System East Orange, NJ			
01-01965-24 11/25/02	Healthcare Inspection Summary Review, Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results			
02-01980-34 12/16/02	Healthcare Inspection, Patient Treatment Issues, Orlando VA Healthcare Center Orlando, FL			
02-00265-35 12/16/02	Healthcare Inspection, Medical and Surgical Care Issues at the Department of Veterans Affairs Northern Indiana Health Care System Fort Wayne, IN			
01-01968-41 12/24/02	Healthcare Inspection, Evaluation of Veterans Health Administration Medical Record Security and Privacy Practices			
02-00972-44 12/31/02	Healthcare Inspection, Evaluation of the Veterans Health Administration’s Contract Community Nursing Home Program			
02-02706-45 1/10/03	Healthcare Inspection, Quality of Care Issues, Amarillo VA Health Care System Amarillo, TX			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
HEALTHCARE INSPECTIONS (Cont'd)				
03-00003-56 2/4/03	Healthcare Inspection, Medical Treatment Issues, VA Greater Los Angeles Healthcare System Los Angeles, CA			
03-00052-74 3/18/03	Healthcare Inspection, Medical Oxygen System at the VA Medical and Regional Office Center Wilmington, DE			
ADMINISTRATIVE INVESTIGATIONS				
02-01946-11 10/31/02	Administrative Investigation, Nonprofit Research and Education Corporation Issue VA Medical Center Miami, FL			
02-01289-20 11/19/02	Administrative Investigation, Physician Time and Attendance Issue, James A. Haley Veterans' Hospital Tampa, FL			$4,779
02-01912-33 12/13/02	Administrative Investigation, Use of Government Resources Issues, Fort Rosecrans National Cemetery San Diego, CA			$868
02-02754-32 12/18/02	Administrative Investigation, Physician Board Certification Issue, Veterans Health Administration, VA Central Office Washington, DC			
02-02351-37 1/2/03	Administrative Investigation, Acceptance of Speaking Fees and Donations from Pharmaceutical Companies, VA San Diego Healthcare System San Diego, CA			$30,687
02-02419-57 2/12/03	Administrative Investigation, Physician Time and Attendance Issue, Edward Hines, Jr. VA Hospital Hines, IL			
02-02938-58 2/13/03	Administrative Investigation, Privacy Act Issue, New Mexico VA Health Care System Albuquerque, NM			
03-00346-71 3/17/03	Administrative Investigation, Compensation and Acceptance of Travel Payments Issues, VA Medical Center Lexington, KY			$7,700
02-02875-72 3/18/03	Administrative Investigation, Use of Official Time Issue, VA Medical Center Augusta, GA			
TOTAL:	**78 Reports**	**$43,984,795**	**$3,441,493**	**$15,822,223**

APPENDIX B

STATUS OF OIG REPORTS UNIMPLEMENTED FOR OVER 1 YEAR

The Federal Acquisition Streamlining Act of 1994 provides guidance on prompt management decisions and implementation of OIG recommendations. It states a Federal agency shall complete final action on each recommendation in an OIG report within 12 months after the report is finalized. If the agency fails to complete final action within this period, the OIG will identify the matter in their semiannual report to Congress until the final action is completed. This appendix summarizes the status of OIG unimplemented reports and recommendations.

The OIG requires that management officials provide documentation showing the completion of corrective actions on OIG recommendations. In turn, OIG reviews status reports submitted by management officials to assess both the adequacy and timeliness of agreed-upon implementation actions. When a status report adequately documents corrective actions, OIG closes the recommendation. If the actions do not implement the recommendation, we continue to monitor progress.

The number of reports in this category declined significantly, dropping from 80 in FY 1996 to only 10 as of March 31, 2003. The following chart lists the total number of unimplemented OIG reports and recommendations by organization. It also provides the total number of unimplemented reports and recommendations issued over 1 year ago (March 31, 2002, and earlier).

Unimplemented OIG Reports and Recommendations

VA Office	Total		Issued 3/31/02, and Earlier	
	Repts	Recoms	Repts	Recoms
VHA	33	116	6	15
A&MM[1]	22	46	0	0
VBA	7	20	3	8
I&T[2]	2	24	0	0
VHA/S&LE[3]	1	15	1	15
Total	**65**	**221**	**10**	**38**

The OIG is particularly concerned with three reports on VHA operations, issued in 1996, 1997, and 1999, respectively, with recommendations that still remain open. The following information provides a summary of reports over a year old with open recommendations.

1 Office of Acquisition and Materiel Management (A&MM)
2 Office of Information and Technology (I&T)
3 Office of Security and Law Enforcement (S&LE)

Veterans Health Administration

Unimplemented Recommendations and Status

Report: *Evaluation of VHA's Policies and Practices for Managing Violent and Potentially Violent Psychiatric Patients, 6HI-A28-038, 3/28/96*

Recommendation:

1. The Under Secretary for Health should explore network flagging systems that would ensure employees at all VAMCs are alerted when patients with histories of violence present for treatment to their medical centers.

Status: This requires action by both the VHA Chief Consultant for Mental Health and the VHA Information Office. The VHA Chief Consultant for Mental Health is finalizing the patient flagging directive and anticipates approval by mid-August 2003. The VHA Information Office is using VISN 7 to beta test an automated system-wide tracking program for patient advisory flags. Full field activation is scheduled for September 2003.

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Report: *Internal Controls Over the Fee-Basis Program, 7R3-A05-099, 6/20/97*

Recommendations: The Under Secretary for Health should improve the cost effectiveness of home health services by:

1. Establishing guidelines for contracting for such services.
2. Providing contracting officers with benchmark rates for determining the reasonableness of charges.

Status: The Chief Consultant, Geriatrics and Extended Care has reported that a comprehensive home health care reimbursement policy is not possible at this time and will need to follow the development of a regulation that will govern a large portion of VA's home care arrangements, particularly in skilled home care. VHA's Business Office and Office of General Counsel are drafting the regulation. VHA will publish a complete home health care reimbursement policy within three months of the regulation's being promulgated.

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Report: *Evaluation of VHA's Income Verification Match (IVM) Program, 9R1-G01-054, 3/15/99*

Recommendations: The Under Secretary for Health should:

1. Require the Chief Network Officer to ensure that VISN Directors establish performance standards and quality monitors, and strengthen procedures and controls for means testing activities and billing and collection of Health Eligibility Center (HEC) referrals to include:
   (a) obtaining quarterly reports from the HEC of the number of cases referred and the number of cases billed and not billed for each facility, and
   (b) reviewing a sample of cases to verify appropriate billing and compliance with the 60-day billing standard and to determine why unbilled referrals were not billed and taking appropriate corrective action.

2. Requiring the Chief Information Officer to develop performance measures and monitor periodic performance reports to ensure the HEC:
   (a) performs multiple year income verification, and
   (b) transmits all billing referrals to facilities.
3. Expedite action to centralize means testing activities at the HEC.

Status: The VHA Chief Business Officer has initiated the IVM process in March 2003, with actual reports to be available during the third quarter, FY 2003. The VHA Chief Business Officer has procedures and/or policies in place to address all of the recommendations outlined above. The multiple year IVM process will be initiated first quarter FY 2004, since multiple year data is not currently available. VHA has received first line approval for implementing the new means test program.

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Report: *Administrative Investigation, Irregularities in Employee Relocation Reimbursements and the Workers' Compensation Program, VAMC West Palm Beach, FL,* 00-01632-117, 7/20/01

Recommendations: The VISN 8 Director should:
1. Take appropriate administrative action against the VAMC Director for allowing the Chief, Human Resources Management Service, and the Chief, Business Office to avoid Federal requirements to report job-related injuries, and bill associated costs, to the Department of Labor.
2. Take appropriate administrative action against the Chief, Human Resources Management Service for violating Federal requirements to report job-related injuries, and bill associated costs, to the Department of Labor.
3. Take appropriate administrative action against the VAMC Director and Chief, Human Resources Management Service for not ensuring that medical center employees are adequately informed of their workers' compensation program rights, and against the VAMC Director for improperly denying three employees continuation of pay benefits.

Status: In regards to the VAMC Director, the VHA Human Resources Management Group has formulated a proposal for review by the Office of General Counsel and Office of Human Resources Management (HRM) in accordance with the VA Secretary's memo regarding senior management conduct and performance issues, dated June 8, 2001. The level of appropriate administrative action for the Human Resource Manager was predicated on an advisory opinion from HRM regarding a finding that a prohibited personnel practice had been committed in connection with another matter involving that facility. HRM provided the advisory opinion on March 28, 2003.

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Report: *Evaluation of VHA Coding Accuracy and Compliance Program,* 01-00026-68, 2/25/02

Recommendation:
1. The Under Secretary for Health should issue additional guidance requiring that VHA facility managers set incremental goals to reduce error rates to less than 5 percent, complete the billing process within a reasonable timeframe, make immediate corrections when billing errors are identified, and implement uniform coding and billing internal review processes.

Status: This requires action by both the VHA Compliance and Business Integrity (CBI) Office and the Business Office. The CBI Office stated a work group met in January 2003 to focus on the more technical, operational issues pertaining to the implementation of the final version of the CBI indicators. These indicators include coding accuracy, billing accuracy, and accuracy of clinical provider information to support third-party bills, and presence of documentation to support first-party (co-pay) bills. The Executive Committee of the National Leadership Board recommended that the indicators, when completed, should be included in ongoing review of operations discussions with VISN Directors. The proposed CBI indicators are currently being considered by the performance measures workgroup. Final implementation of the revised indicators is projected for July 2003. The Chief Business Office is currently conducting a pilot improvement effort in VISN 10. Site visits have been completed at six VISN 10 sites and initial observations have been drafted. Once all site visits have been completed, the Business Office operations strategy document and implementation plan will be developed to incorporate the recommended changes. These documents are scheduled for completion by May 2003.

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Report: *Audit of the Medical Care Collection Fund (MCCF) Program,* 01-00046-65, 2/26/02

Recommendations: The Under Secretary for Health should improve MCCF program operations by:

1. Improving medical record documentation so that treatment is coded accurately and properly billed.
2. Ensuring that VA medical facilities use the preregistration software as required.
3. Establishing performance standards for clinical and administrative staff involved in all phases of the MCCF (patient registration, coding, billing, collection, and utilization review) and requiring VISN and VA medical facility Directors to monitor performance results and take action to improve performance gaps (such as making additional resources available for MCCF functions as justified by performance standards).

Status: This requires action by three VHA offices.

1. The VHA Information Office is revising the health information management handbook that reflects the MCCF enhancements. The handbook will be in the coordination process shortly.
2. The VHA Chief Business Office has submitted a project request for an enhancement to the VHA diagnostic measures to include a new report on a national basis on the use of the preregistration software. The addition of this report to the diagnostic measures website will allow VHA to ensure that facilities are using the software as required. This enhancement is scheduled for implementation by Spring 2004.
3. The VHA Compliance and Business Integrity Office stated a work group met in January 2003 to focus on some of the more technical, operational issues pertaining to the implementation of the final version of the Compliance and Business Integrity indicators. These indicators include coding accuracy, billing accuracy, and accuracy of clinical provider information to support third-party bills, and presence of documentation to support first-party (co-pay) bills. The Executive Committee of the National Leadership Board was briefed in January 2003 and recommended that the indicators, when completed, should be included in ongoing review of operations discussions with VISN Directors. The proposed indicators are currently being considered by the performance measures workgroup. Final implementation of the revised indicators is projected for July 2003.

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Joint (Veterans Health Administration and Office of Security and Law Enforcement)

Unimplemented Recommendations and Status

Report: *Review of Security and Inventory Controls Over Selected Biological, Chemical, and Radioactive Agents Owned by or Controlled at VA Facilities,* 02-00266-76, 3/14/02

Recommendations: The Under Secretary for Health, in conjunction with senior policy, research, and operations manages, need to:

1. Redefine and strengthen security and access requirements and procedures for safeguarding high-risk agents and materials used in VA facilities, such as the agents on the Centers for Disease Control and Prevention Select Agents List, other biological agents, toxic chemicals, and certain pharmaceuticals that might be targeted for use by terrorists.
2. Improve personnel access controls and reduce vulnerabilities to theft of selected agents by implementing measures such as the consistent use of photo identification badges with expiration dates, installation of electronically controlled entry points to and from sensitive areas, and use of key-card systems, video surveillance, and/or biometric systems.
3. Review documents related to VA leased-space to others for research use (e.g., to an affiliated university) to ensure that VA's agreements define security responsibilities and limitations.
4. Clarify VA's accountability and responsibilities for actions of non-VA persons supervising VA or non-VA research in VA facilities or in VA space leased to other institutions.
5. Strengthen controls for authorizing and procuring high-risk materials and agents including biological agents, and ensure that inventory, transfer, and validated destruction policies and procedures account for biological agents and chemicals at all times. Additionally, procedures should outline appropriate requirements for the use of witnesses to verify transfer and destruction processes.
6. Require managers to transfer, dispose of, or establish delimiting dates on select agents no longer in use and stored in research and clinical laboratories.
7. Reevaluate the extent of compliance with radiation safety and handling/delivery procedures, particularly vendor deliveries after regular working hours and on weekends. In addition, facility managers should require contractors and vendors to provide evidence that background and legal histories on their employees are checked before they are allowed to access sensitive VA areas.
8. Strengthen human resource management controls and procedures to consistently verify or update non-citizens' legal residence or employment status while working in VA facilities or on VA matters, including students and contractors.
9. Reevaluate the adequacy of security clearance level requirements for employees who could have access to or work with highly sensitive agents and materials.
10. Take action on non-citizen employees without valid legal status and notify appropriate legal authorities.
11. Take action on any noncitizens with access to VHA research and clinical laboratories if they are considered "restricted persons" according to the USA Patriot Act.
12. Ensure clearance and checkout procedures extend to employees without compensation and contract employees.
13. Issue guidance to revise local disaster plans to include provisions for responding to terrorist activities.
14. Direct managers at all facilities to perform vulnerability assessments of their physical research and clinical laboratories and consistently implement security measures.
15. Provide researchers and other appropriate personnel necessary training on security issues, including security of high-risk and sensitive agents, and procedures to forward requests for research articles through their managers and the facility Freedom of Information Act officer.

Status: This report requires action by VHA and the Office of Security and Law Enforcement (S&LE). On March 21, 2002, the VA Deputy Secretary requested the Under Secretary for Health and the Assistant Secretary for Policy and Planning to provide him a joint report that certifies that all the recommendations have been completed by September 30, 2002. As of March 31, 2003, 15 of 16 recommendations remain unimplemented. The remaining unimplemented actions include the following. The Office of Research and Development will systematically review all research sites over the next 3 years as part of its infrastructure program to identify and continue to fund equipment needs that include security devices. To comply with federal regulations, VHA needs to reevaluate actions taken and planned to ensure they have fully addressed the security and inventory controls over any sensitive or dangerous biological, chemical, and radioactive agents or materials owned by or controlled at VA facilities - not just those used in VHA research laboratories. The OIG recommendations made to VHA are consistent with requirements outlined in the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (42 Code of Federal Regulations 73). According to the Centers for Disease Control and Prevention Laboratory Security and Emergency Response Guidance for Laboratories Working with Select Agents, issued December 6, 2002, these requirements are for clinical and research laboratories where select agents are used under biosafety levels 2, 3, or 4. The guidance includes instructions regarding personnel, risk assessments, and inventory controls. The OIG recommendations are also consistent with the United and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA Patriot) Act of 2001, which prohibits restricted persons from access to select agents. Violation of either of these statutes carries potential criminal penalties. Therefore, it is important that all VAMC directors who have biosafety levels 2, 3, or 4 laboratories at their facilities certify that VHA guidance is implemented. The S&LE office has drafted a revised VA Directive and Handbook 0710, "Personnel and Classified Information Security" and it is in Department-wide concurrence. After receiving concurrences, they will both be published. Also in January 2003, the office began revising VA Directive and Handbook 0730, "Security and Law Enforcement." Expected publication is by the end of FY 2003. As an interim measure to immediately address this issue, VHA and S&LE issued a joint memorandum on July 29, 2002 to VHA field facilities. This memorandum contained instructions for conducting assessments and making immediate changes to the physical security of VHA clinical and research laboratories. The memorandum instructed field facilities to apply already existing Department physical security standards. Based on that memorandum, OS&LE inspectors have begun reviewing VHA clinical and research lab security as part of routine, on-site program inspections.

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Veterans Benefits Administration

Unimplemented Recommendations and Status

Report: *Audit of the Compensation and Pension Program's Internal Controls at VA Regional Office, St. Petersburg, FL,* 99-00169-97, 7/18/00

Recommendations: The Under Secretary for Benefits should:

1. Establish a positive control Benefits Delivery Network (BDN) system edit keyed to employee identification number that ensures employee claims are adjudicated only at the assigned regional office of jurisdiction and prevents employees from adjudicating matters involving fellow employees and veterans service officers at their home office.
2. Determine the feasibility of direct input and storage of rating decisions in BDN.
3. Establish a BDN system field for third-person authorization and a control to prevent release of payments greater than $15,000 without the third-person authorization.
4. Issue guidelines for the proper and effective handling of drop-mail to ensure continued entitlement.
5. Take steps necessary to make use of Social Security numbers as employee identification numbers, and tie BDN access to Social Security numbers.
6. Verify continued entitlement of beneficiaries who are over 100 years of age, and beneficiaries with whom VBA has not had contact during a prescribed period of time.

Status:

1. The Modern Awards Processing (MAP) system, which is the replacement system to BDN, will incorporate this control. In the interim, VBA will ensure adherence to existing policy regarding the sensitivity access levels and the monitoring of the generated reports.
2. National deployment of Rating Board Automation 2000 addresses this recommendation. Full utilization is targeted for July 2003.

3. The MAP will audit and require a third electronic signature anytime an award would generate payment in excess of the applicable limit. In addition, program integrity plans include utilization of data mining to identify areas such as these for potential fraud. As MAP is designed, this control will be incorporated. Final stages of MAP deployment is scheduled in the fourth quarter, FY 2004.
4. A nationwide contract has been initiated for on-line access to address information at all VAROs. Full implementation in scheduled for the third quarter, FY 2003.
5. VBA completed the assessment study to determine the implementation strategy for the new BDN computer system and the newest version of the Bull Operating System. The implementation will eliminate the need for multiple BDN identifications. The estimated completion date is December 2003. In addition, VBA completed the evaluation of whether to modify the BDN to include Social Security numbers. These modifications will be completed by November 2003.
6. Writeouts for beneficiaries turning 100 years old in 2003 and all beneficiaries 101 years and older were generated to all VAROs in January 2003. The OIG will close this recommendation when VBA starts VARO oversight.

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Report: *Audit of VBA's Income Verification Match Results*, 99-00054-1, 11/8/00

Recommendation:

1. The Under Secretary for Benefits should complete necessary data validation of beneficiary identifier information contained in Compensation and Pension master records to reduce the number of unmatched records with Social Security Administration. (This is a repeat recommendation from the 1990 OIG report.)

Status: The installation date for the project initiation request modifying the Social Security number verification process is April 2003. Once it is installed, VBA will validate the output and release it to the field, if it is acceptable.

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Report: *Follow Up Evaluation of the Causes of Compensation and Pension (C&P) Overpayments,* 01-00263-53, 2/20/02

Recommendation:

1. The Under Secretary for Benefits should reduce C&P benefit overpayments by revising processing procedures and clarifying VA policy to proactively suspend benefits when bad addresses cannot be resolved.

Status: Due to the FY 2003 continuing resolutions, the procurement package for a nationwide address locator service was delayed. VBA anticipates contracting for the service and software no earlier than the fourth quarter, FY 2003. Once the software is delivered to the VAROs, VBA will issue the manual change to the field stations. These procedures are anticipated to be in place by the end of FY 2003.

APPENDIX C

INSPECTOR GENERAL ACT REPORTING REQUIREMENTS

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

IG Act References	Reporting Requirement	Page
Section 4 (a) (2)	Review of legislation and regulations	47
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-49
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-49
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	65 (App. B)
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	i
Section 5 (a) (5)	Summary of instances where information was refused	74 (App. C)
Section 5 (a) (6)	List of audit reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use	57 to 63 (App. A)
Section 5 (a) (7)	Summary of each particularly significant report	i to v
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	75 (Table 1)
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	76 (Table 2)
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	74 (App. C)
Section 5 (a) (11)	Significant revised management decisions	74 (App. C)
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	74 (App. C)
Section 5 (a) (13)	Information described under section 05(b) of the Federal Financial Management Improvement Act of 1996 (Public Law 104-208)	74 (App. C)

INSPECTOR GENERAL ACT REPORTING REQUIREMENTS (CONT'D)

Prior Significant Recommendations Without Corrective Action and Significant Management Decisions

The IG Act requires identification of: (i) significant revised management decisions, and (ii) significant management decisions with which the OIG is in disagreement. During this 6-month period, there were no reportable instances under the Act.

Obtaining Required Information or Assistance

The IG Act requires the OIG to report instances where access to records or assistance requested was unreasonably refused, thus hindering the ability to conduct audits or investigations. During this 6-month period, there were no reportable instances under the Act.

Federal Financial Management Improvement Act of 1996 (Public Law 104-208)

The IG Act requires the OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with the requirements of Public Law 104-208. The OIG has reported in our Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2002 and 2001 (Report Number 02-01638-47, Issued 1/22/03), that corrective action dates in the VA remediation plan are all in the future.

Reports Issued Before this Reporting Period Without a Management Decision Made by the end of the Reporting Period

The IG Act requires a summary of audit reports issued before this reporting period for which no management decision was made by the end of the reporting period. There were no internal OIG reports unresolved for over 6 months. However, there were three contract review unresolved reports for which a contracting officer decision has not been made for over 6 months. They are: Review of Proposal Submitted by Spacelabs Medical, Under Solicitation Number RFP-797-FSS-99-0025, for Medical Equipment and Supplies (Report No. 01-01584-136, Issued 9/14/01); Review of Proposal Submitted by the University of Washington Under Solicitation Number RFP V663P-22-02 for Anesthesiology Services at the VA Puget Sound Heath Care System, Seattle Division (Report No. 02-00623-94, Issued 5/1/02); and Review of FSS Proposal Submitted by Johnson & Johnson Health Care Systems, Inc., on Behalf of Lifescan, Inc., Under Solicitation Number M5-Q52D-01 (Report No. 01-02822-126, Issued 6/26/02). These reports will be closed after the OIG receives the contracting officer price negotiation memorandum following contract awards. The contract awards are anticipated by December 2003.

Statistical Tables 1 and 2 Showing Number of Unresolved Reports

As required by the IG Act, Tables 1 and 2 provide statistical summaries of unresolved and resolved reports for this reporting period. Specifically, they provide summaries of the number of OIG reports with potential monetary benefits that were unresolved at the beginning of the period, the number of reports issued and resolved during the period with potential monetary benefits, and the number of reports with potential monetary benefits that remained unresolved at the end of the period.

TABLE 1 - RESOLUTION STATUS OF REPORTS WITH QUESTIONED COSTS

This table provides the resolution status information required by the IG Act. It summarizes the reports with questioned costs.

RESOLUTION STATUS	NUMBER OF REPORTS	QUESTIONED COSTS (In Millions)
No management decision by 9/30/02	0	$0
Issued during reporting period	18	$15.8
Total Inventory This Period	**18**	**$15.8**
Management decision during reporting period		
Disallowed costs (agreed to by management)	18	$15.8
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Period	**18**	**$15.8**
Total Carried Over to Next Period	**0**	**$0**

Definitions:

- **Questioned Costs**

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

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

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

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

TABLE 2 - RESOLUTION STATUS OF REPORTS WITH RECOMMENDED FUNDS TO BE PUT TO BETTER USE BY MANAGEMENT

This table provides the resolution status information required by the IG Act. It summarizes the reports with recommended funds to be put to better use by management.

RESOLUTION STATUS	NUMBER OF REPORTS	RECOMMENDED FUNDS TO BE PUT TO BETTER USE (In Millions)
No management decision by 9/30/02	8	$20.3
Issued during reporting period	14	$44.0
Total Inventory This Period	**22**	**$64.3**
Management decisions during reporting period		
Agreed to by management	11	$7.1
Not agreed to by management	0	$0.0
Total Management Decisions This Period	**11**	**$7.1**
Total Carried Over to Next Period	**11**	**$57.2**

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 D

OIG OPERATIONS PHONE LIST

Investigations

Headquarters Investigations Washington, DC .... (202) 565-7702
Northeast Field Office (51NY) New York, NY .... (212) 951-6307
Boston Resident Agency (51BN) Bedford, MA .... (781) 687-3139
Newark Resident Agency (51NJ) Newark, NJ .... (973) 297-3338
Pittsburgh Resident Agency (51PB) Pittsburgh, PA .... (412) 784-3818
Washington Resident Agency (51WA) Washington, DC .... (202) 530-9191
Southeast Field Office (51SP) Bay Pines, FL .... (727) 398-9559
Atlanta Resident Agency (51AT) Atlanta, GA .... (404) 929-5950
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Nashville Resident Agency (51NV) Nashville, TN .... (615) 695-6373
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Kansas City Resident Agency (51KC) Kansas City, KS .... (913) 551-1439
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Phoenix Resident Agency (51PX) Phoenix, AZ .... (602) 640-4684
San Diego Resident Agency (51SD) San Diego, CA .... (619) 400-5326
San Francisco Resident Agency (51SF) Oakland, CA .... (510) 637-1074
Seattle Resident Agency (51SE) Seattle, WA .... (206) 220-6654, ext 31

OIG OPERATIONS PHONE LIST (CONT'D)

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Healthcare Regional Office Washington (54DC) Washington, DC .... (202) 565-8452
Healthcare Regional Office Atlanta (54AT) Atlanta, GA .... (404) 929-5961
Healthcare Regional Office Bedford (54BN) Bedford, MA .... (781) 687-2134
Healthcare Regional Office Chicago (54CH) Chicago, IL .... (708) 202-2672
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Healthcare Regional Office Los Angeles (54LA) Los Angeles, CA .... (310) 268-3005

Audit

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Central Office Operations Division (52CO) Washington, DC .... (202) 565-4434
Contract Review and Evaluation Division (52C) Washington, DC .... (202) 565-4818
Financial Audit Division (52CF) Washington, DC .... (202) 565-7913
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APPENDIX E

GLOSSARY

A&MM	Acquisition and Materiel Management
BDN	Benefits Delivery Network
C&P	Compensation and Pension
CAP	Combined Assessment Program
CBI	Compliance and Business Integrity
CIO	Chief Information Officer
CNH	Community Nursing Home
DAS	Data Analysis Section
DAS	Deputy Assistant Secretary
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FOIA/PA	Freedom of Information Act/Privacy Act
FSS	Federal Supply Schedule
FTE	Full Time Equivalent
FY	Fiscal Year
HEC	Health Eligibility Center
H/HHA	Homemaker/Home Health Aide
HRM	Office of Human Resource Management
HUD	Department of Housing and Urban Development
I&T	Office of Information and Technology
IG	Inspector General
IT	Information Technology
IV	Intravenous
IVM	Income Verification Match
MAP	Modern Awards Processing
MCCF	Medical Care Cost Funds
MCI	Master Case Index
NCA	National Cemetery Administration
NM	Nurse Manager
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
OMB	Office of Management and Budget
S&LE	Office of Security and Law Enforcement
SA	Special Agent
SSA	Social Security Administration
U.S.	United States
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Cover photo of
Captain John Paul Jones and sailors
Bronze Relief Sculpture
U.S. Navy Memorial
Washington, DC by
Lawrence J. Timko
VA OIG, Washington, DC

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Internet Homepage:	http://www.va.gov/oig/hotline/hotline.htm
E-mail Address:	vaoighotline@mail.va.gov

Department of Veterans Affairs
Office of Inspector General
Semiannual Report to Congress

October 1, 2002 - March 31, 2003