April 1, 2002
to
September 30, 2002

Office of Inspector General

Semiannual Report to Congress

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 September 30, 2002. 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.

OIG oversight of VA programs resulted in systemic improvements and increased efficiencies in areas of medical care, benefits administration, procurement, financial management, information technology, and facilities management. OIG audits, investigations, and other reviews identified $297.9 million in monetary benefits, for an OIG return on investment of $11 for every dollar expended.

Our criminal investigators concluded 375 investigations involving fraud or other criminal conduct in VA's programs and operations. During the semiannual period, special agents effected 237 arrests, and investigations led to over $70 million in monetary benefits to VA (recoveries or savings). Our most significant investigation led to an indictment charging a former Veterans Health Admistration (VHA) nurse with ten counts of first degree murder. The indictment charged that the nurse caused the death of ten veteran patients by administering a lethal dose of a paralytic muscle relaxant identified as succinylcholine. In the Philippines, a team of OIG employees conducted a proactive investigative review related to suspected fraud associated with individuals receiving VA benefits. These efforts resulted in the proposed termination from VA benefit rolls of almost 600 payees, with a projected 5-year cost savings of over $21 million. To date, this investigation has led to the arrest of 15 defendants. Our Atlanta investigation of an $11 million embezzlement by a Veterans Benefits Administration employee resulted in the arrest and conviction of 12 defendants.

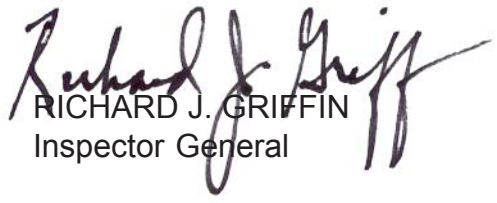
Our audit oversight of VA, the second largest Department in the Federal Government, focused on determining how programs can work better, while improving service to veterans and their families. Our audit of veterans benefits payments involving unreimbursed medical expense claims found that processing errors and potential fraud results in annual beneficiary overpayments of as much as $125 million and underpayments totaling as much as $20 million. An audit of VA medical center management of miscellaneous supply inventories presented opportunities to reduce

miscellaneous supplies by over 77 percent or about $54 million. Also, an audit of VA Consolidated Mail Outpatient Pharmacies inventories presented opportunities to reduce excess inventories by about 45 percent or $29 million.

Our healthcare inspectors focused on quality of care issues in VA, which operates the largest healthcare system in the United States. Inspectors visited a number of facilities to respond to congressional and other special requests concerning healthcare-related matters. We also completed two summary evaluation reports that should assist VHA managers in improving controls and procedures for managing patients who have acute and chronic pain. In one evaluation, we found that the quality of care in VHA mental health programs could be improved if there were more consistency among providers in managing long-term narcotics prescriptions for patients who have pain. In a second evaluation, we found that VHA has made significant strides in implementing its pain management initiative; however, facility compliance varied from site to site. In addition, our inspectors completed 20 additional reports and reviewed 69 patient care and services issues brought to our attention. Inspectors found instances where clinicians had not met the standards of care, patients were not treated satisfactorily, and safety procedures designed to protect patients were not followed. Our inspectors also oversaw VHA directors' efforts to address allegations of poor care and services, and they provided clinical consultative support to investigators on six criminal cases. In addition, inspectors provided oversight of the work conducted by VHA's Office of the Medical Inspector.

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. The 22 CAP reviews completed during this 6-month 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
Inspector General

TABLE OF CONTENTS

HIGHLIGHTS OF OIG OPERATIONS

This semiannual report highlights the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for the 6-month period ended September 30, 2002. The following statistical data highlights OIG activities and accomplishments during the reporting period.

	Current 6 Months 4/1/02 - 9/30/02	FY 2002 10/1/01 - 9/30/02
DOLLAR IMPACT	**Dollars in Millions**	
Funds Put to Better Use	$250.6	$799.3
Dollar Recoveries	$8.7	$35.0
Fines, Penalties, Restitutions, and Civil Judgments	$38.6	$43.5
RETURN ON INVESTMENT		
Dollar Impact ($297.9) / Cost of OIG Operations ($26.0)	11 : 1	
Dollar Impact ($877.8) / Cost of OIG Operations ($54.7)		16 : 1
OTHER IMPACT		
Arrests	237	452
Indictments	166	357
Convictions	170	331
Administrative Sanctions	278	481
ACTIVITIES		
Reports Issued		
Combined Assessment Program	22	34
Audits	17	26
Contract Reviews	29	60
Healthcare Inspections	22	37
Administrative Investigations	5	12
Investigative Cases		
Opened	347	744
Closed	375	727
Healthcare Inspections Activities		
Oversight Reviews	99	205
Consultations	6	12
Technical Reviews	28	72
Hotline Activities		
Contacts	7,916	15,952
Cases Opened	722	1,403
Cases Closed	746	1,522

OFFICE OF INVESTIGATIONS

Overall Focus

This semiannual period, the Office of Investigations concluded 375 investigations resulting in 336 judicial actions (indictments and convictions) and over $70 million recovered or saved. Investigative activities resulted in the arrests of 237 individuals who had committed crimes involving VA programs and operations or on VA facilities. Many significant cases were investigated; here are some examples.

Veterans Health Administration

A former VA Veterans Health Administration (VHA) nurse was indicted by a grand jury and charged with ten counts of first degree murder under state statutes. The indictment charges that the nurse, while working at a VA medical center (VAMC), caused the deaths of ten veteran patients by administering a lethal dose of a paralytic muscle relaxant identified as succinylcholine. During the investigation, exhumations and autopsies of patients who had died while at the VAMC were conducted. However, the autopsies and subsequent laboratory tests failed to identify a manner or means of death. Subsequently, with the advent of new advanced forensic testing and modern technologies, new laboratory tests disclosed the presence of succinylcholine in the deceased patients. After extensive review of medical records, it was determined that none of the ten veteran patients was legally administered succinylcholine or had a reason to have taken the drug. The investigation is continuing and judicial actions are pending.

Veterans Benefits Administration

A former Veterans Benefits Administration (VBA) employee pled guilty to 23 counts of theft of Government funds, 1 count of conspiracy to commit money laundering, and 1 count of conspiracy. The individual, a 30-year VA employee, embezzled more than $11 million in VA funds from 1993 until August 2001. She used her access to the VA computer system to create bogus benefits accounts by resurrecting deceased veterans in the computer system. After the accounts were created, she manipulated the computer system to issue large VA checks or regular monthly checks to her co-conspirators. When the co-conspirators received the checks, a portion, usually one third, was remitted to the individual as payment for her services. The 11 co-conspirators entered guilty pleas and were sentenced to a cumulative total of 294 months in jail and 35 years probation. Judicially ordered restitution to date has totaled over $23 million. Property (to include cash, insurance policies, jewelry, cars, boats, motor homes, and a submarine) with an appraised value of over $2.7 million has been seized or forfeited. Sentencing of the individual is pending, and she could receive up to 20 years in jail.

The Office of Inspector General (OIG) conducted a proactive investigative project based on suspected fraud associated with the delivery of benefits to veterans residing in the Philippines. A team of OIG employees conducted the review that resulted in the proposed termination from VA benefits rolls of almost 600 payees. To date, the cost savings to VA is over $2.5 million in overpayments with a projected 5-year cost savings of over $21 million by terminating VA payments of those individuals who are not entitled to the benefits. Nine criminal cases were initiated and 15 individuals were arrested. These cases were investigated and referred to the Philippines National Bureau of Investigation. One of these cases involved a large criminal organization that was involved in submitting claims to VA on behalf of potential beneficiaries. The organization would often submit false documentation to VA in support of the claim. The two ringleaders of this organization were

among those arrested. Additionally, 147 other subjects have been identified as having been involved in this scheme.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for $228 Million

Audits and evaluations were focused on operations and performance results to improve service to veterans. During this reporting period, 66 audits, evaluations, and reviews, including Combined Assessment Program (CAP) reviews were conducted that identified opportunities to save or make better use of approximately $228 million.

Veterans Health Administration

Our audit of VAMC management of miscellaneous supply inventories reported that VA could reduce large excess inventories by using automation for control of stock levels and purchasing smaller quantities. We reported miscellaneous supply inventories could be reduced by about $54 million. Also, an audit of VA Consolidated Mail Outpatient Pharmacies inventories found that VA could reduce pharmaceutical inventories by effectively using automated inventory management system controls and developing better management reports. We reported that inventories could be reduced by about $29 million.

Veterans Benefits Administration

Our audit of VBA's processing of beneficiaries with unreimbursed medical expenses found that beneficiaries were submitting inappropriate claims for medical expenses that have affected their benefit payments. We found a significant number of erroneous payments were made to claimants. The processing errors and potential program fraud resulted in annual beneficiary overpayments of as much as $125 million and underpayments of as much as $20 million.

Office of Management

As part of the annual Consolidated Financial Statements audit, we issued five management letters addressing financial reporting and control issues. The letters provided Department managers additional automated data processing security observations and advice that will enable the Department to improve accounting operations and internal controls. None of the conditions noted had a material effect on the FY 2001 Consolidated Financial Statements, but correction of the conditions was considered necessary for ensuring effective operations.

Contract Review and Evaluation

During the period, we completed 29 contract reviews - 18 preaward and 11 postaward reviews. These reviews identified monetary benefits of about $37 million resulting from contractor actual or potential overcharges to VA.

OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections (OHI) participated with the Offices of Audit and Investigations on 18 CAP reviews and reported on specific clinical issues warranting the attention of VA managers. OHI reviewed health care issues and made 111 recommendations to improve operations, activities, and the care and services provided to patients.

At the request of the Secretary of Veterans Affairs, we participated in one follow up CAP review on actions taken to implement recommendations reported during the last semiannual report. The review included recommendations to improve the quality of care, sanitation, control over pest infestations, and infection controls. In conjunction with the CAP reviews, OHI completed two summary evaluations. Our evaluation of procedures for managing patients who have acute and chronic pain found that the quality of care in VHA mental health programs could be improved if there were more consistency among providers in managing long-term narcotics prescriptions for patients who have pain. Our evaluation of the VHA pain management initiative found that VHA has made significant strides in implementing its initiative; however, facility compliance varied from site to site. Our findings are important to VA managers as they continue to improve controls and procedures for managing patients who have acute and chronic pain.

Our inspectors visited a number of facilities this period to respond to congressional and other special requests and reviewed patient allegations pertaining to quality of care issues received by the OIG Hotline. We completed 20 Hotline cases, reviewed 69 issues, and made 57 recommendations to correct conditions identified and improve the health care and services provided to patients. Our findings and recommendations resulted in managers issuing new and revised procedures, realigning resources, and making environmental and safety improvements.

We monitored the completion of inquiries sent to VHA for action and resolution. We completed, resolved, and reported on 99 of these cases and reviewed 136 issues, and we assessed the appropriateness of VHA's response to the inquiries. OHI also assisted the Office of Investigations on 6 criminal and fraud cases that required reviews of medical evidence, and we performed 28 technical reviews of pending VHA policies, congressional bills, and newly developing programs. We also monitored the work of VHA's Office of Medical Inspector, National Center for Patient Safety, and Office of Research Compliance.

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. The identification and reporting of issues such as these are integral to the goal of improving the efficiency and effectiveness of the Government. During the reporting period, the Hotline received 7,916 contacts. We opened 722 cases. We closed 746 cases, of which 221 contained substantiated allegations (30 percent). The monetary impact resulting from these cases totaled over $60,000. Hotline staff generated 164 responses to inquiries received from members of the Senate and House of Representatives. The cases we opened led to 70 administrative sanctions against employees and 90 corrective actions taken by management to improve VA operations and activities. Examples of some of the issues addressed by Hotline include: a veteran's misuse of his VA educational benefits, misuse of official time and e-mail for personal reasons, abuse of authority, patient safety violations, contracting irregularities, and instances of misconduct by VA employees.

Information Technology and Data Analysis

During this reporting period, this Division provided OIG personnel with more than 40 enhancements of the Master Case Index (MCI), the OIG's enterprise database. Most notably, the Division implemented an Intranet site housing OIG policies, procedures, and shared calendars. Additionally, the Division developed new MCI modules to track the fugitive felon match, as well as allocations in awards, travel, training, and supplies.

The Data Analysis Section (DAS) extracts and analyzes data in VA computer files and systems. The DAS develops proactive computer profiles that search VA computer data for patterns of inconsistent or irregular records with a high potential for fraud. They refer these leads to OIG auditors and investigators for further review. During this reporting period, the DAS completed 108 ad hoc requests for information and data submitted from all OIG operational elements. The DAS also supported all OIG CAP reviews. Considerable effort was also spent in developing programs to match data in seven VBA and VHA databases with data submitted by the U.S. Marshals Service and the State of California concerning fugitive felons.

Follow Up on OIG Reports

The Operational Support Division continually tracks the VA staff actions to implement OIG audits, inspections, and reviews. As of September 30, 2002, there were 68 open OIG reports containing 250 unimplemented recommendations with over $4 billion of actual or potential monetary benefits. During this reporting period, the OIG closed 87 reports and 592 recommendations with a monetary benefit of $379 million after obtaining information that VA officials had fully implemented corrective actions.

Status of OIG Reports Unimplemented for Over 3 Years

VA management officials are required to provide the OIG with documentation showing the completion of corrective actions taken on OIG reports. In the majority of cases, program offices provide the OIG with documentation of the actions required to implement the reports in a reasonable period. However, the OIG is concerned about four VHA reports (one report issued in each of FY 1996 and 1997, and two reports issued in 1999). Details about these reports can be found beginning on page 58.

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.

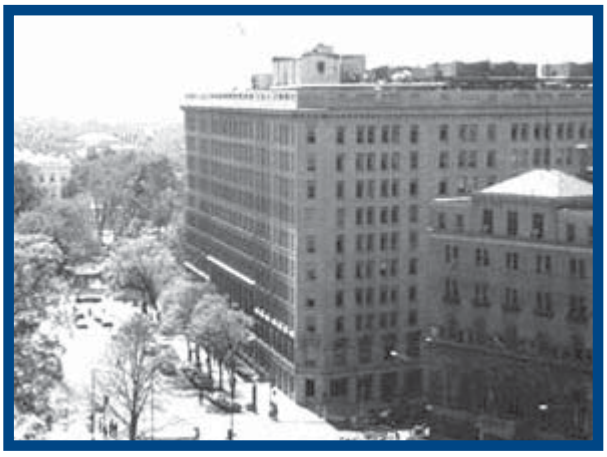
The Veterans Administration was founded in 1930, when Public Law 71-536 consolidated the Veterans' Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers.

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 and Planning (Policy, Planning, and Security and Law Enforcement);
- Human Resources and Administration (HRA) (Diversity Management and Equal Employment Opportunity, Human Resources Management, Administration, and Resolution Management);

- Public and Intergovernmental Affairs; and
- Congressional Affairs.

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

Resources

While most Americans recognize the VA as a Government agency, few realize that it is the second largest Federal employer. For FY 2002, VA had approximately 209,000 employees and a $51.8 billion budget. There are an estimated 25 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 190,000 of VA's employees work in VHA. Health care was funded at almost $23 billion, approximately 44 percent of VA's budget in FY 2002. VHA provided care to an average of 57,000 inpatients daily. During FY 2002, there were almost 47 million episodes of care for outpatients. There were 163 hospitals, 137 nursing home units, 206 Vietnam veterans centers, 43 domiciliaries, and 914 outpatient clinics (including hospital clinics).

Veterans benefits were funded at $28.9 billion, about 56 percent of VA's budget in FY 2002. Over 13,000 VBA employees at 57 VAROs provided benefits to veterans and their families. Almost 2.7 million veterans and their beneficiaries received compensation benefits valued at $26 billion. Also, over $3 billion in pension benefits were provided to veterans and survivors. VA life insurance programs had 4.3 million policies in force with a face value of over $595 billion. Almost 309,000 home loans were guaranteed in FY 2002, with a value of almost $40 billion.

The National Cemetery Administration operated and maintained 120 cemeteries and employed over 1,400 staff in FY 2002. Operations of NCA and all of VA's burial benefits accounted for approximately $389 million of VA's budget. Interments in VA cemeteries continue to increase each year, with 89,000 estimated for FY 2002. Approximately 314,000 headstones and markers were 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 appropriate actions.

Organization

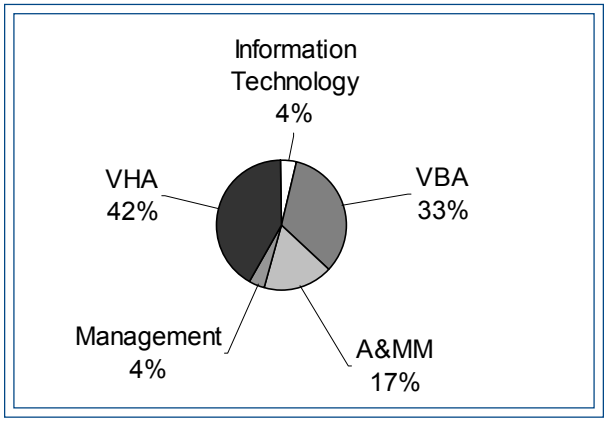
Allocated full-time equivalent (FTE) employees from appropriations for the FY 2002 staffing plan were as follows:

OFFICE	ALLOCATED FTE
Inspector General	4
Counselor	4
Investigations	120
Audit	176
Management and Administration	55
Healthcare Inspections	46
TOTAL	**405**

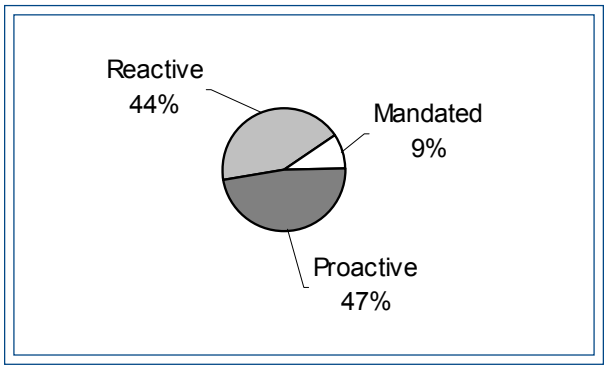
In addition, 24 FTE are reimbursed for a Department contract review function.

FY 2002 funding for OIG operations is $54.7 million, with $52 million from appropriations and $2.7 million through a reimbursable agreement. Approximately 74 percent of the total funding is for salaries and benefits, 5 percent for official travel, and the remaining 21 percent for all other operating expenses such as contractual services, rent, supplies, and equipment.

The percentage of OIG resources, which has been devoted during this semiannual reporting period to VA's major organizational areas, is indicated in the following chart.



The following chart indicates the percentage of OIG resources that has been applied to mandated, reactive, and proactive work.



Mandated work is required by law and the Office of Management and Budget (OMB). 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

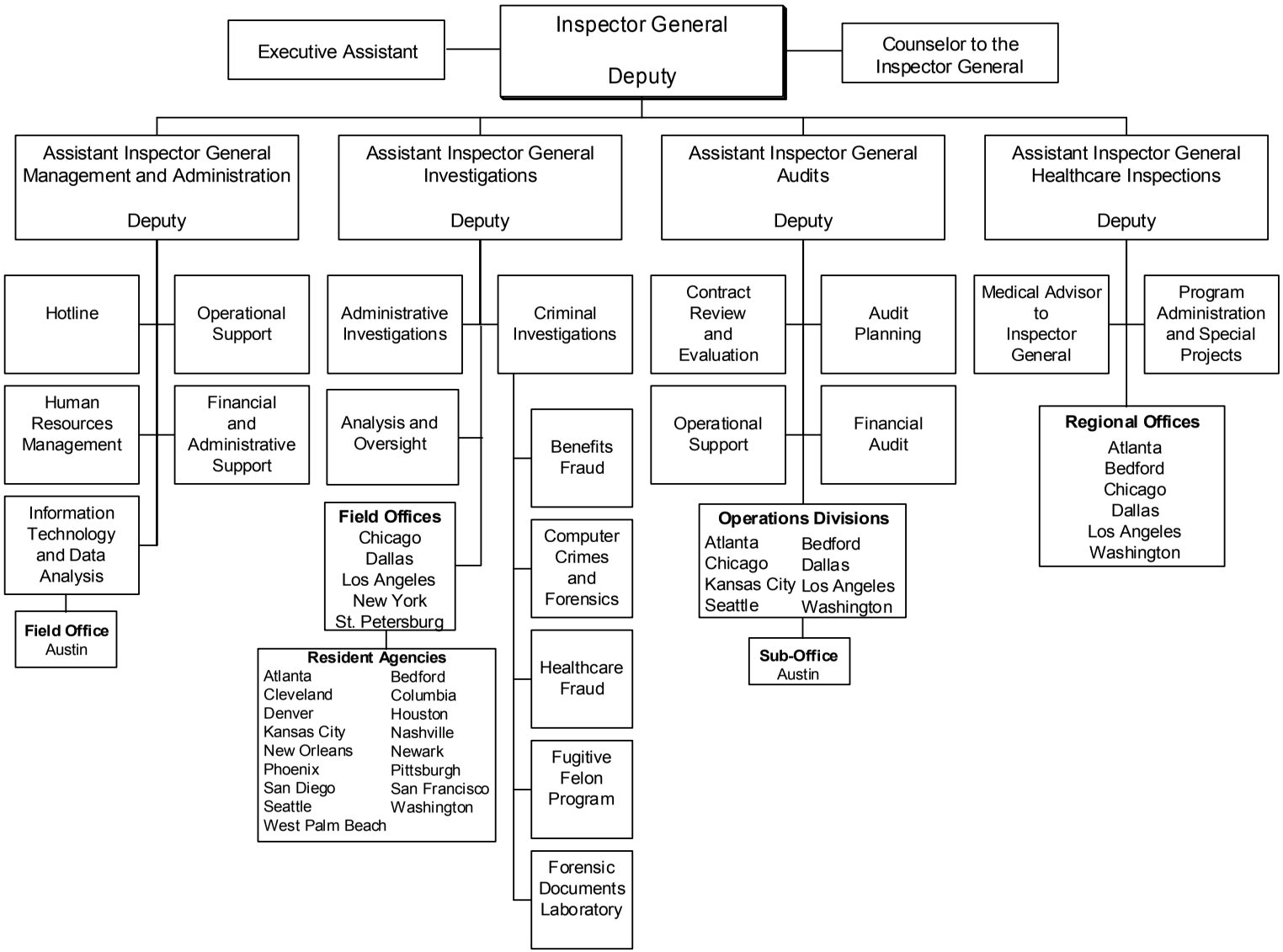
OIG Mission Statement

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 perform their duties fairly, honestly, and with the highest professional integrity.

Department of Veterans Affairs
Office of Inspector General



COMBINED ASSESSMENT PROGRAM

Reports Issued

During the period April 1, 2002 through September 30, 2002, we issued a total of 22 Combined Assessment Program (CAP) reports. Of the 22 CAP reports, 13 were for VA health care systems/VA medical centers (VAMCs), 8 for VA regional offices (VAROs), and 1 for a VA medical and regional office center (VAM&ROC).

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 facilities. They provide an independent and objective assessment of key operations and programs at 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 and safety of patient care. 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 activities, 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 14 health care facility CAP reports. Included in our coverage of the 14 sites was one review of a VA medical and regional office center. See Appendix A for the full title and date of the CAP reports issued this period. These 14 reports relate to the following VA medical facilities:[1]

- Central Alabama Veterans Healthcare System, Alabama
- Central Arkansas Veterans Healthcare System, Arkansas
- VA Long Beach Healthcare System, California

[1] Due to committing significant resources to the special review of all VARO one-time payments, the Office of Audit was not available to review management controls at VA San Diego and Central Texas Veterans Healthcare Systems. Office of Audit staff did review management controls at the other 12 health care facilities.

VA Medical Center
Loma Linda California

- VA Loma Linda Healthcare System, California
- VA San Diego Healthcare System, California
- VA Connecticut Healthcare System, Connecticut
- John J. Pershing VAMC, Poplar Bluff, Missouri
- VAMC Durham, North Carolina
- VAMC Fayetteville, North Carolina
- VAM&ROC Fargo, North Dakota
- VAMC Providence, Rhode Island
- James H. Quillen VAMC, Johnson City, Tennessee
- Central Texas Veterans Healthcare System, Temple, Texas
- William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin

Summary of Findings

Our reviews identified the following areas that required the attention of VHA management.

Financial Management and Administration

Management was not consistently adhering to established financial policies and procedures. VHA management needs to improve oversight in financial management activities in order to provide accurate and reliable financial information.

Accounts Receivable

VA has established policies and procedures for establishing and collecting accounts receivable. However, compliance with these policies and procedures was not consistent. The lack of management oversight has contributed to inefficient collection efforts and to weaknesses in the management of the Medical Care Cost Fund (MCCF) and other accounts receivable financial activities.

- MCCF controls were deficient at 7 of 10 facilities where we reviewed the medical center's collection efforts. Billing actions were untimely and collections were not pursued aggressively. Medical coding was deficient at 4 of the 10 facilities where we reviewed coding. These deficiencies resulted in the inability to properly bill for services. VHA needs to ensure that appropriate and accurate medical insurance claims are filed and that all insurance claims are supported by medical record documentation. Additionally, VHA needs to reduce errors in coding which lead to delays or non-payment.

- Accounts receivable procedures (other than MCCF) were deficient at 3 of 6 facilities where we tested accounts receivable procedures. VHA needs to aggressively pursue delinquent debts of current and former employees and should also initiate timely collection of Federal accounts receivable.

Agent Cashier

- Agent cashier controls were deficient at 4 of 8 facilities where we reviewed the agent cashier function. Security in agent cashiers' offices was inadequate. Agent cashiers did not deposit and post MCCF receipts timely, resulting in checks negotiability expiring before the facility was able to deposit the reimbursement checks. At some sites we noted convenience checks were not included in the unannounced audits of agent cashier operations.

Procurement

The OIG has identified the need to improve procurement practices in VA as one of the Department's most serious management challenges. 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 11 of 12 facilities tested. 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 6 of 11 facilities tested. Controls needed to be strengthened to ensure that acquisition and materiel management employees ensure price reasonableness for noncompetitive contracts, and that contract provisions include procedures to help ensure contract compliance. Contract administration efforts also needed improvement. For example, at one facility visited, none of nine locally awarded clinical service contracts were forwarded to VACO to facilitate quality assurance and oversight.

- Medical supply inventory management was deficient at 8 of 10 facilities and non-medical inventory management was deficient at 5 of 10 facilities where we tested these issues. We found that inventory levels exceeded current requirements resulting in funds being tied up unnecessarily in excess inventories.

Information Technology

A wide range of vulnerabilities in VHA's automated information system were identified that could lead to misuse of sensitive information and data. VA has established comprehensive information security policies, procedures, and guidelines; however, CAP reviews found that facility policy development, implementation, and compliance were inconsistent. In addition, there is 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 2001 Government Information Security Results Act audit that identified information security vulnerabilities that place the Department at risk of denial and/or disruption of service attacks on mission critical systems, and unauthorized access to and disclosure of sensitive financial data and data subject to Privacy Act protection.

- Information technology (IT) security deficiencies were found at 12 sites where IT security was reviewed. We found that: (i) security plans were not prepared or updated, (ii) contingency plans lacked key elements, (iii) access to VHA's Veterans Health Information Systems was not effectively monitored, and/or (iv) background investigations were not requested or documentation was not available for contract personnel working in sensitive areas.

VA Medical Center
Long Beach, CA

Pharmacy

VA has established policies, procedures, and guidelines for pharmacy security and accountability of controlled substances and other drugs. We reviewed pharmacy security and/or controlled substances accountability at 12 facilities. Control weaknesses were identified at all 12 facilities. The lack of management oversight at the facility, VISN, and national levels has contributed to inefficient practices and to weaknesses in drug accountability and security.

- Controlled substance inspections procedures were inadequate to ensure compliance with VHA policy and Drug Enforcement Administration regulations at the 12 sites 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 6 of 12 sites where controls were reviewed. We advised local management that 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.

Health Care Management

- We inspected medical record security at 6 facilities visited. We found security deficiencies at all six facilities. Patients' medical information was not protected against deliberate or inadvertent misuse or disclosure as required. Computer terminals were not always positioned in a manner that would prevent unauthorized persons from viewing patient information, and computer privacy screens were not routinely used. Controls were not in place to identify inappropriate access to restricted patient records. Employees were not always aware of computer incident reporting procedures. Confidentiality management training and strategies were inconsistent. Medical records were transported in unsecured envelopes and medical records were left unattended in examination rooms. Employees did not have access to shredders for disposal of confidential information.

- We inspected abnormal test and procedure result notifications at 14 facilities. Written policies and management of abnormal test and procedure results, including patient notification in primary care departments, were deficient at 8 of 14 facilities. VHA managers needed to improve procedures for notifying providers and patients of abnormal test and procedure results. Providers needed to be vigilant in reviewing the results of the tests and procedures they ordered, communicating the results to patients, documenting the notification in the medical records, and providing timely follow up instructions and care to the patients.

- We inspected the homemaker/home health aide program at 4 facilities. At all four facilities, we found program managers were not obtaining information related to quality assurance from community health agencies providing services, as required by VHA directive. Also at 2 facilities, there was no oversight committee monitoring operations or quality of care issues; billing invoices were not monitored for discrepancies; initial patient assessments to determine clinical eligibility were incomplete; and the need for continued services was not reviewed every 90 days, as mandated by VHA directive.

- We reviewed the delivery of primary care services to mental health patients at 7 facilities. Mental heath patients had a designated primary care provider or team. Chronic diseases were appropriately assessed and managed. Preventive disease strategies were implemented. Additionally, mental health patients were generally satisfied with their care. However, providers needed to be vigilant in documenting that they had reviewed and discussed results with their patients for the tests and procedures they had ordered for them.

- We reviewed the delivery of primary care services to mental health patients at 6 facilities. Medical record documentation showed that in all 6 facilities patients were enrolled in primary care and that their chronic diseases were appropriately assessed and managed. Clinicians at 2 of 6 facilities were inconsistent in their documentation that preventive disease strategies were implemented, and patient interviews revealed that patients in the same 2 facilities had difficulty scheduling an appointment with their primary care provider or team within 7 days. At 3 of 6 facilities reviewed, we found inconsistencies in clinicians' documentation that patients were informed of abnormal test results.

- We inspected employee background investigation procedures at 6 facilities. We found deficiencies at all six facilities. The facilities' human resources management offices did not always request background investigations from the Office of Personnel Management for all licensed independent practitioners, as required by policy. The human resources management office employees did not always document the dates they sent requests for background investigations so we could not determine if they were sent within 14 work-days of the employees' appointments, as required. Additionally, at one VAMC we found 36 percent of employees did not have background checks.

Survey Results

Inpatient Surveys

We interviewed 242 inpatients receiving care at 14 facilities. We surveyed inpatients in mental health, medical, surgical, long-term care, and intensive care units. We discussed the results with local management officials before leaving the sites. We found that 75 percent of the inpatients interviewed rated the care they received at VA as good, very good, or excellent. Results were discussed with managers during site visits.

Outpatient Surveys

We surveyed 371 VA outpatients at 14 facilities to ascertain their satisfaction with the care they received. We surveyed patients in the primary care, mental health, and specialty care clinics. We also surveyed outpatients who were in waiting areas of various support services such as pharmacy, radiology, and laboratory.

Overall, 92 percent of the outpatients rated the quality of care as good, very good, or excellent. Ninety percent of the respondents stated that procedures were generally performed on time as scheduled.

Convesely, outpatients expressed concern about the timeliness of receiving prescriptions. Only 36 percent of the outpatients told us they received their prescriptions within 30 minutes. Seventy percent of the respondents said they received counseling by pharmacists when they received new prescriptions. Respondents using the mail-out pharmacies were generally more satisfied with the process. The survey showed that 84 percent of the respondents said they received their medication refills in the mail before running out of their medications. We discussed our survey results with managers during site visits.

Physical Plant Environment Surveys

We visited clinical care areas at 14 facilities, and conducted inspections of 151 individual areas. We inspected outpatient clinic areas, inpatient wards, domiciliaries, emergency rooms, nursing home care units, and operating rooms. Inspections showed that managers needed to improve procedures to secure medications, provide unobstructed hallways, ensure privacy, and strengthen cleaning and sanitation procedures. In addition, managers needed to better publicize the patient representatives' names, locations, and phone numbers in case patients or family members wanted to voice complaints or concerns. We discussed survey results with managers during site visits.

Employee Surveys

We mailed survey questionnaires to employees at the 14 facilities visited during the reporting period. We received 2,145 responses. We discussed the results of these surveys with managers during site visits.

Most employees expressed satisfaction with their general work conditions and the quality of patient care provided to patients. The surveys showed that 73 percent of the respondents believed that the quality of care at their respective facilities was either good, very good, or excellent. The surveys also showed that 76 percent of the respondents said they would recommend treatment at their respective facilities to family members or friends.

Some respondents were concerned about working conditions at their facilities. For example, 35 percent of the respondents said that staffing was not sufficient in their respective work areas to provide safe care to patients. The survey results also showed that 38 percent of the respondents believed housekeeping support was not sufficient to ensure the hospital was clean and sanitized. In addition, the surveys showed that 37 percent of the respondents believed that work orders for needed repairs were not addressed promptly to ensure safe environments.

VA Regional Office
Manchester, NH

The majority of employees responded positively to questions concerning patient incidents. However, while 88 percent of the respondents reported they were generally comfortable in self-reporting errors that involved patient care, 77 percent indicated they were comfortable reporting errors that involved colleagues. Furthermore, 63 percent believed that constructive actions were taken when errors were reported.

Combined Assessment Program Overview - Benefits

In FY 2002, we increased CAP review coverage of VBA regional office centers. These reviews focus on the delivery of monetary benefits to veterans and their dependents.

OIG staff assessed whether management controls are in place and working effectively in VBA. We evaluated key areas of concern derived from a concentrated and continuing analysis of VBA management information. Our special agents conducted fraud and integrity awareness briefings and used a new videotape they developed related to VBA activities.

During this period, we issued nine CAP reports on the delivery of benefits, one of which was a VA medical and regional office center. See Appendix A for the full title and date of the CAP reports issued this period. These nine reports relate to the following VA regional office facilities:

- VARO Denver, Colorado
- VARO Des Moines, Iowa
- VARO Manchester, New Hampshire
- VARO Newark, New Jersey
- VARO New York, New York
- VAM&ROC Fargo, North Dakota
- VARO Cleveland, Ohio
- VARO Waco, Texas
- VARO Roanoke, Virginia

Summary of Findings

Information Technology

Our increased CAP review coverage of VBA facilities in FY 2002 identified a wide range of vulnerabilities in VBA systems similar to those we identified during VHA CAP reviews. The deficiencies could lead to misuse of sensitive automated information and data. Although VA has established comprehensive information security policies, procedures, and guidelines, CAP reviews found that facility policy development, implementation, and compliance were inconsistent. Recent CAP findings show a need to improve access controls, contingency planning, risk assessment, and security training. We found inadequate management oversight contributing to inefficient practices, and to inadequate information security and physical security of assets.

CAP reviews identified the following areas that required the attention of VBA management:

- Information technology security was deficient at 8 of 9 facilities reviewed. Risk assessments needed to be conducted, contingency plans required revision, and testing of contingency, security, and disaster recovery plans was necessary.

- VARO management needed to strengthen security over the Beneficiary Delivery Network (BDN) at 4 of 9 facilities visited. BDN is the computerized system that VAROs use to process benefit claims. Physical security over terminals logged on to BDN should be strengthened. Managers also needed to better control access to BDN and to comply with VBA security requirements. VAROs should strive for 100 percent compliance and should have effective procedures for detecting and correcting instances of noncompliance.

VA Regional Office
Newark, NJ

Compensation and Pension

- The timeliness of compensation and pension (C&P) claims processing needed improvement at all nine facilities visited. C&P claims had avoidable processing delays and/or procedural errors that affected workload and timeliness measures. Managers need to monitor the effectiveness of recent initiatives to improve claims processing timeliness and provide refresher claims processing training for veteran service center staff.

- Other C&P deficiencies found during our visits included untimely and inaccurate actions on system error messages, veteran service center personnel not properly reducing the pension benefits of veterans hospitalized for extended periods at Government expense, and staff not taking appropriate action on mail notices indicating death of a C&P beneficiary.

Other VBA Programs

- VBA's processing and timeliness over vocational rehabilitation and employment claims needed improvement. Data entry, claims processing, and case monitoring errors were noted at 6 of 9 facilities visited. Management needs to process claims for vocational rehabilitation benefits in a timely manner, enter accurate data, and monitor claims status.

- Government purchase card program deficiencies existed at 6 of 9 facilities visited. Reconciliation and supervisory approvals were not performed, single purchase limits were exceeded, cards were not deactivated timely, and purchase card duties were not separated.

- We found that improvements were needed in fiduciary accounting and field examination controls and procedures at 7 of 8 facilities visited. Management needed to improve the oversight of incompetent beneficiaries' funds by ensuring thorough field examinations were conducted, appropriate recommendations or referral were made, and were completed within the required time. Also, fiduciary accountings should be submitted timely and accurately.

- CAP reviews of loan administration activities were conducted at four of the regional loan centers during this reporting period. The loan administration unit did not maintain and update lender files at 3 of 4 facilities. We found lender files that did not contain records of lender performance or documentation of servicing deficiencies. At one facility, none of the lender files reviewed contained loan-servicing documentation dated subsequent to 1998. Therefore, we concluded that the VAROs had not effectively monitored lender performance for at least the last 4 years (1998 to 2002).

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.

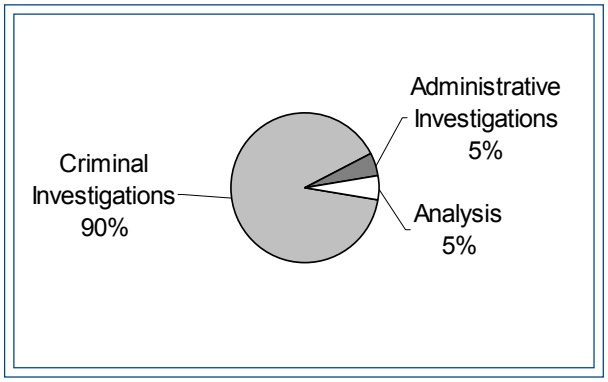
I. Criminal Investigations Division - The Division is primarily responsible for conducting investigations into allegations of criminal activities related to the programs and operations of VA. Criminal violations are referred to the Department of Justice for prosecution. The Division is also responsible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

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

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

Resources

The Office of Investigations has 120 FTE allocated to the following areas.



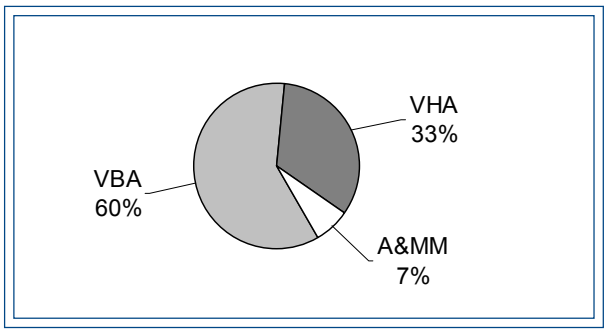
I. CRIMINAL INVESTIGATIONS DIVISION

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



Overall Performance

Output

- 375 investigations were concluded during the reporting period.

Outcome

- Arrests - 237
- Indictments - 166
- Convictions - 170
- Monetary benefits - $70.3 million ($38.6 million - fines, penalties, restitutions, and civil judgments; $27.3 million - efficiencies/funds put to better use; and $4.4 million - recoveries)
- Administrative sanctions - 206

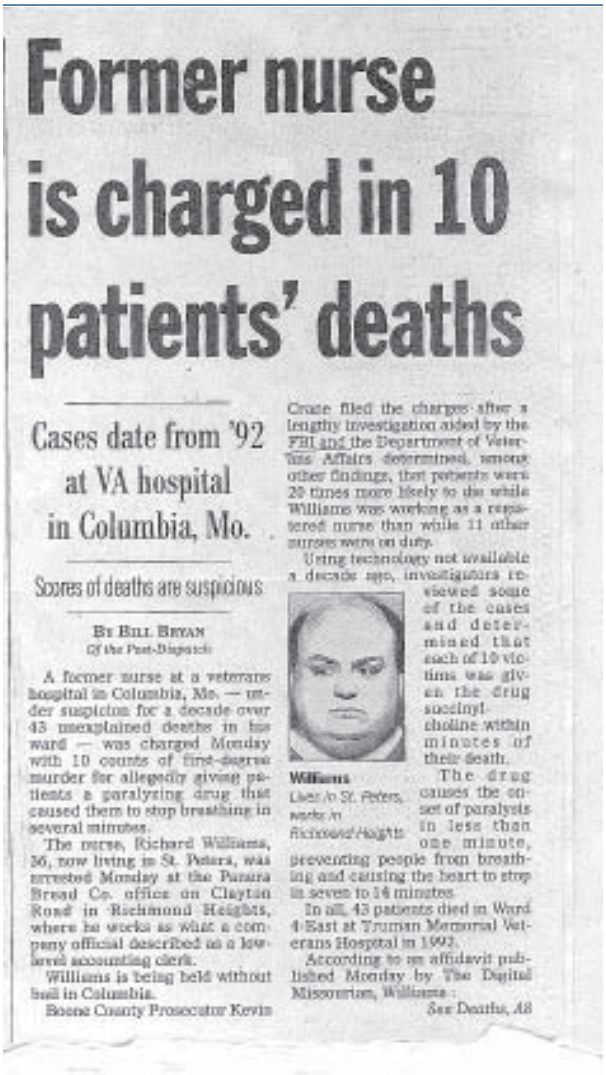
Veterans Health Administration

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 40 individuals who committed crimes on VHA properties.

Murder

A former VA nurse was indicted by a grand jury and charged with ten counts of first degree murder under state statutes. The indictment charges that the nurse, while working at a VAMC, caused the deaths of ten veteran patients by administering a lethal dose of a paralytic muscle relaxant identified as succinylcholine. This matter was the subject of an extensive investigation, which began in 1992 by the FBI and VA OIG.

St. Louis Post Dispatch
St. Louis, MO
Tuesday, June 4, 2002



Former nurse is charged in 10 patients' deaths

Cases date from '92 at VA hospital in Columbia, Mo.

Scores of deaths are suspicious

By Bill Bryan
Of the Post-Dispatch

A former nurse at a veterans hospital in Columbia, Mo. — under suspicion for a decade over 43 unexplained deaths in his ward — was charged Monday with 10 counts of first-degree murder for allegedly giving patients a paralyzing drug that caused them to stop breathing in several minutes.

The nurse, Richard Williams, 36, now living in St. Peters, was arrested Monday at the Panera Bread Co. office on Clayton Road in Richmond Heights, where he works as what a company official described as a low-level accounting clerk.

Williams is being held without bail in Columbia.

Boone County Prosecutor Kevin Crane filed the charges after a lengthy investigation aided by the FBI and the Department of Veterans Affairs determined, among other findings, that patients were 20 times more likely to die while Williams was working as a registered nurse than while 11 other nurses were on duty.

Using technology not available a decade ago, investigators reviewed some of the cases and determined that each of 10 victims was given the drug succinylcholine within minutes of their death.

Williams

Lives in St. Peters, works in Richmond Heights

The drug causes the onset of paralysis in less than one minute, preventing people from breathing and causing the heart to stop in seven to 14 minutes.

In all, 43 patients died in Ward 4-East at Truman Memorial Veterans Hospital in 1992.

According to an affidavit published Monday by The Digital Missourian, Williams

See Deaths, A8

An intensive review of selected files by investigative, medical, and forensic specialists identified 13 highly suspicious deaths that had occurred at the VAMC for patients under the care of the nurse. During the investigation, exhumations and autopsies of patients who had died while at the VAMC were conducted. However, the autopsies and subsequent laboratory tests failed to identify a manner or means of death. Subsequently, with the advent of new advanced forensic testing and modern technologies, new laboratory tests disclosed the presence of

succinylcholine in the deceased patients. After extensive review of medical records, it was determined that none of the ten veteran patients was legally administered succinylcholine, or had a reason to have taken the drug. The investigation is continuing.

Employee Integrity

Theft/Diversion of Pharmaceuticals

- A self-employed independent pharmacist was sentenced to 2 years' probation and ordered to pay $301,510 in restitution. The pharmacist pled guilty to charges of theft of Government property and conspiracy. He was given probation as a result of his plea agreement and extensive cooperation during this investigation. Three co-defendants were previously found guilty on similar charges and will be sentenced later this year. This was a joint investigation with the Food and Drug Administration (FDA), Office of Criminal Investigations. The indictment disclosed that from 1997 to 2000, three VAMC employees conspired to remove large amounts of non-controlled pharmaceutical drugs from the VAMC pharmacy. The employees then exchanged these drugs for cash with the pharmacist, who sold them to the public from his privately owned pharmacy business. Loss to the Government exceeded $1.3 million over the 3 years.

- A VA nurse was arrested and charged with felony counts of narcotics tampering and possession. A joint investigation by the VA OIG and FDA, Office of Criminal Investigations, revealed the nurse had diverted narcotics from a VA hospital. More specifically, she removed narcotics from drug packets and replaced the narcotics with normal saline solution to disguise her theft. The nurse diverted the drugs for her own use and consumption and deprived VA patients of their pain medication. The nurse confessed to the crime and stated that she administered Demerol mixed with saline to patients. Further judicial actions are pending.

- A former VAMC licensed practical nurse was arrested by OIG agents pursuant to a 17-count Federal indictment for possession of controlled narcotics by misrepresentation or fraud. This individual diverted Demerol, Roxicet, Oxycodone, and morphine sulfate for his own use. He would divert these drugs by withdrawing medications in the name of patients and then used the drugs himself. This individual diverted medications an average of 4 to 6 times per workday over a period of approximately 9 months.

- The uncle of a VA supervisory pharmacist was sentenced for his role as a co-conspirator with the pharmacist in the distribution of diverted drugs taken from a VAMC. The subject was sentenced to 70 months' incarceration and 3 years' supervised release, and was ordered to pay $4,140 in restitution. The subject's role was to act as a go between, allowing the drugs to be distributed on the street. The investigation disclosed that over 233,000 dosage units of Schedule II and III narcotics were diverted from the VA pharmacy. The Drug Enforcement Administration and VA OIG jointly conducted the investigation. The pharmacist is to be sentenced at a later date.

Embezzlement

- An individual pled guilty to one count of theft of Government funds in the embezzlement of $23,055 from a VAMC. A joint VA OIG and U.S. Secret Service investigation established that the individual, an accounting technician, used her VAMC computer to access the VA's financial management system and caused six checks and seven electronic fund transfers to be issued to her.

Theft of Government Property

- A VA canteen service manager pled guilty to a one count information charging him with theft of public money. An audit of the canteen service

revealed $17,298 in cash from the sale of goods and services was never deposited into the VA Federal credit union. The manager admitted to embezzling these funds to pay off gambling debts.

- The former administrator and a former bookkeeper of a long-term care nursing facility were charged with five counts and two counts of theft, respectively, relative to their diversion of $42,000 from the facility's patient trust account into the facility's operating account to pay themselves increased salaries. Approximately $25,000 of this amount was diverted from one veteran patient. Judicial actions are pending.

Credit Card Fraud

Chicago Sun-Times
Chicago, IL

METRO

VA official accused of stealing $177,000

By Curtis Lawrence
Staff Reporter

Federal prosecutors Friday charged a 28-year veteran of the Hines VA Hospital with using his corporate credit card to purchase $177,000 of computer equipment that he sold for cash.

Paul Romito, 49, of Westmont had been the business manager for the hospital's surgical services department until he resigned in May after his alleged scheme was uncovered

- A former VAMC business manager was sentenced to 10 months' incarceration followed by 2 years' supervised release, and was ordered to pay $177,649 in restitution to the Government. The individual oversaw all administrative matters within the VAMC's surgical service and procured items for the service with a VA-issued credit card. Without authorization, the individual used the credit card to fraudulently purchase $177,649 worth of laptop computers and peripheral equipment. He then sold most of the items to an associate, keeping the money he received. In turn, the associate sold the computers and peripherals to various pawnshops. Both individuals previously pled guilty to theft of Government funds. The associate was sentenced earlier to serve 12 months' incarceration followed by 3 years' supervised release, and was ordered to pay $170,149 in restitution to the Government.

Other Employee Misconduct

- A former VAMC chief of podiatry was found guilty of bribery, theft, and wire fraud after a weeklong jury trial. The conviction resulted from a joint FBI and VA OIG investigation into corruption and fraud in a VAMC podiatry program. The investigation determined that the former chief accepted $25,000 from an individual in exchange for falsifying VA records that indicated the individual was present in the VAMC residence program. In addition, VA paid the individual and his spouse for working in the VA program when they were seldom present and were actually conducting a podiatry practice in another state. The co-defendants previously pled guilty to similar charges. Sentencing is pending.

- An individual formerly employed as a VAMC patient services assistant pled guilty to an indictment charging the individual with two counts of attempted sexual exploitation of a minor under 15 years of age. This conviction followed an investigation that revealed the individual was downloading child pornography from the internet

using a VA computer while on duty at the VAMC. This is a joint investigation with a local law enforcement agency. Sentencing is pending.

Workers Compensation Fraud

- An individual pled guilty to a one count information charging her with a false statement to obtain Federal workers' compensation. The investigation found the individual, a VAMC registered nurse, was hired in December 1979. In July 1980, she reported an injury to her back while lifting a patient out of bed. On the individual's March 1986 statement of disability, she reported that the 1980 injury to her back prevented her from standing or sitting for any length of time. The individual also reported being unable to drive, climb stairs, or walk fast because of severe pain. However, videotape evidence and personal observation identified the individual walking and driving an automobile with no apparent difficulty. It was determined that from March 1998 through April 1999, the individual worked in various facets of a small retail clothing business owned and operated by the individual and her family. Cost savings to the Government are expected to be $500,000.

Abuse of Veterans by Caregivers

- A VA nursing assistant was sentenced for assaulting a VA patient. The individual was sentenced to 3 days in jail and fined $450. The sentence was issued after the individual pled guilty to charges of harassment, disorderly conduct, and public drunkenness. A joint investigation by VA OIG and VA police disclosed the individual broke the jaw of a VA patient while giving patient care. The individual alleged the patient grabbed his hand, and during his attempts to free himself he accidentally struck the patient with his elbow. Subsequent investigation revealed the injured patient was in full restraints at the time of the injury. The first responding VA police officer noted knuckle marks on the patient's face and detected the odor of alcohol on the VA nursing assistant. A blood alcohol lab test was conducted and found the individual to be legally intoxicated.

- A VAMC nursing assistant was found guilty for assaulting an 84-year-old veteran patient in his care. The investigation found the individual was observed by another VAMC employee hitting the veteran at least twice on the forehead and multiple times around the ankles and thighs. The patient was hit with such force that it caused abrasions and a subdural hematoma that was considered life threatening at the time. The veteran had been placed in arm and leg restraints earlier that day and could not defend himself.

Possession of Illegal Drugs

- A former VAMC pharmacist and her boyfriend have been indicted for possession of a controlled substance with intent to distribute, and with possession of marijuana with intent to distribute. These charges are the result of a joint investigation conducted by a local law enforcement organization and the VA OIG. During a search by law enforcement authorities, approximately 19,700 dosage units of medications were found, including Schedule III and IV controlled substances, and a significant amount of marijuana. The former pharmacist admitted that she had removed the medications and controlled substances from the VAMC where she was formerly employed.

Theft of Property

- An individual pled guilty and was sentenced to 76 months' incarceration for financial identity fraud. The non-veteran, fraudulently and with criminal intent, obtained the identifying data of more than a dozen VAMC psychiatric in-patients and used the information to obtain credit cards and other instruments in their names. Two associates who were also patients at the VAMC stole the identifying data from routine VAMC daily reports that had been left unguarded.

The Tennessean | Nashville, TN | Friday, September 13, 2002

TENNESSEE & MIDSTATE

No Gun Ri figure receives 2 years in fraud case

Associated Press

An Army veteran who figured in the exposure of the refugee killings at No Gun Ri, South Korea, in 1950 must spend nearly two years in prison and repay more than $400,000 for defrauding the government.

The sentence against Edward Lee Daily of Clarksville was announced yesterday by the U.S. Department of Justice. Daily must spend 21 months in prison, followed by three years of supervised release. He must also repay $412,839 to the U.S. Department of Veterans Affairs.

"This was an amazing fraud perpetrated by Mr. Daily, ... baldly perpetrated upon a lot of people," said U.S. District Judge Aleta Trauger during Daily's sentencing.

Daily was one of a dozen U.S. Army veterans cited by The Associated Press in 1999 as witnesses corroborating the accounts of South Korean survivors that the 7th Cavalry Regiment killed a large number of refugees at No Gun Ri.

He later acknowledged he could not have been there at the time and had learned about the killings secondhand.

From February 1986 through the end of 2001, Daily received compensation from the Department of Veterans Affairs and its predecessor, the Veterans Administration, based on an application he filed listing an injury and claiming POW status, according to the Justice Department.

Benefits included $324,911 in payments wired to his bank and $87,928 in medical care for his claimed service-related disabilities.

When Daily pleaded guilty in March, he admitted in court that he falsely claimed he was a first lieutenant, a Korean prisoner of war and was wounded by shrapnel.

Sumter Camp, Daily's public defender, declined to comment on the sentencing.

A Pentagon investigation last year confirmed that U.S. troops killed refugees at No Gun Ri. At least 35 ex-GIs have described the events to the AP or Pentagon investigators or both. ■

Medical Benefits Fraud

- An individual was sentenced to 21 months' incarceration to be followed by 3 years' supervised release, and was ordered to pay $412,839 restitution to VA. Investigation disclosed that he falsified and altered his military records, and he claimed being captured and a prisoner-of-war, and later escaped from the North Koreans during the Korean War. The individual also falsely claimed he was wounded and received a number of medals. Based upon these false claims, he was qualified to collect disability compensation and medical care benefits from VA that he was not entitled to and did so for a period of 16 years. During a major news network interview, the individual falsely claimed he was a participant in the group of U.S. Army soldiers during the Korean War who were ordered to fire on Korean civilians at No Gun Ri. The investigation disclosed that he was not at No Gun Ri and thus could not have been a participant or witness to the alleged incident.

- The brother of a veteran was arrested and charged with three counts of identity theft and one count of forgery. During this investigation, the subject gave false information that was uncovered after a fingerprint check. Subsequent interviews revealed the subject's true identity. A fraudulent VA medical identification card had been found amongst the subject's belongings. The card contained the subject's picture, but his brother's unique identification. The subject admitted to using the card across the U.S. as well as having fraudulent drivers licenses from numerous states. The VA loss is estimated at over $43,000. Follow up is still being conducted on services obtained from VA in five additional states.

Procurement Fraud

- The president of a construction company pled guilty to mail fraud. An investigation disclosed that between 1994 and 1997 the company received multiple Government construction contracts, including contracts for renovations at VA medical centers. Subsequently, the president applied by mail and received Government progress payments by certifying suppliers and subcontractors had been paid, when, in fact, he routinely failed to pay the suppliers and subcontractors as required. As a result of his actions, a total of ten Government construction programs were delayed, small businesses suffered financial difficulties, and his bonding company declared bankruptcy. The total monetary loss is $1,288,720. The president has been permanently barred from receiving any future Government contracts. Sentencing is pending.

Healthcare Fraud

- A former VAMC audiologist was sentenced to 24 months' imprisonment and 36 months' supervised release, and ordered to pay restitution of $27,300. This investigation revealed the

audiologist sold hearing aids that were U.S. Government property to approximately 75 veterans and 6 non-veterans. The audiologist collected payments from these individuals and kept the funds for his personal benefit.

Veterans Benefits Administration

VBA provides wide-reaching benefits to veterans and their dependants including benefits payments, home loan guaranty services, and educational opportunities. Each of these benefits programs is subject to fraud by those who wish to take advantage of the system. For example, individuals submit false claims for service-connected disability, third parties steal benefit 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.

Murder

- A jury convicted an individual of homicide for the murder-for-hire shooting of her husband, a Navy enlisted man. She was also convicted of theft of VA benefits. During the trial, she took the stand in her own defense despite the prosecution's videotaped exhibits showing her admissions to an undercover officer and a partial confession to the crime after her arrest. She received over $158,000 of VA Dependency and Indemnity Compensation (DIC) benefits as the widow of the deceased. As a result of the guilty verdict, she is not entitled to VA benefits and faces a prison term of 25 years to life. The case was investigated jointly with the state police and Naval Criminal Investigative Service.

Death Match Project

- An ongoing proactive project is being conducted by the VA OIG Information Technology and Data Analysis Division 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 5,557 possible cases. Over 513 investigative cases have been opened. Investigations have resulted in the actual recovery of $5.5 million, with an additional $6.3 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $16.6 million. To

The Republican Journal
Belfast, ME
Thursday, August 8, 2002

CAN JOURNAL

established 1829, Belfast, Maine

RSDAY, AUGUST 8 , 2002 44 PAGES/4 SECTIONS

Small accomplice in murder of husband

BY TANYA MITCHELL

BATH — On Friday morning, a Sagadahoc County jury found former Belfast resident Norma Small guilty of hiring a hitman to kill her husband for insurance money nearly 20 years ago.

The jury deliberated for about 4 1/2 hours over the course of two days before finding the 63-year-old woman guilty of being an accomplice in the Dec. 16, 1983, murder of her husband, Naval Chief Petty Officer Mervin "Sonny" Grotton.

The state charged that Small hired 46-year-old Joel Fuller, formerly of Searsmont, to kill her husband. Grotton was gunned down in the driveway of his Wight Street home as he returned for the weekend from a naval base in Newport, R.I.

Small reported said Fu[ller] for the Small insisted he either commit the murder or find someone else who could. After deciding he could not go through with the shooting, he got Small and Fuller together.

The jury also found Small guilty of theft. In the years following Grotton's death, she had collected more than $180,000 in

"I told them just what they wanted to hear. They were bound and determined that they were going to get their way. I felt threatened and intimidated." — Norma Small

[under fraudu-

defense attorney, Peter Mason of Searsport, suggested Small was making a transaction on Grotton's behalf with permission she obtained prior to his death. There were reportedly insufficient funds in Grotton's account to cover the $5,000 check.

Small's daughter, Rosalyn Grotton also took the witness stand. She recalled events prior to her father's death. Rosalyn said her mother was happy that Sonny Grotton was coming home the weekend of the murder because Small was anxious to have new carpet put in the house for Christmas.

"When you said your mom couldn't wait for your dad to get home, it wasn't because she was dying for your father to come home and that she was dying to see him," asked Assistant Attorney Andr[ew] — Reason

date, there have been 52 arrests on these cases with several additional cases awaiting judicial action.

Employee Misconduct

Theft & Embezzlement

- A former VARO employee pled guilty to 23 counts of theft of Government funds, 1 count of conspiracy to commit money laundering, and 1 count of conspiracy. The individual, a 30-year VA employee, embezzled more than $11 million in VA funds from 1993 until August 2001. She used her access to the VA computer system to create bogus benefits accounts by resurrecting deceased veterans in the computer system. After the accounts were created, she manipulated the computer system to issue large VA checks or regular monthly checks to her co-conspirators. When the co-conspirators received the checks, a portion, usually one-third, was remitted to the individual as payment for her services. The 11 co-conspirators entered guilty pleas and were sentenced to a cumulative total of 294 months in jail and 35 years probation. Judicially ordered restitution to date has totaled over $23 million. Property (to include cash, insurance policies, jewelry, cars, boats, motor homes, and a submarine) with an appraised value of over $2.7 million has been seized or forfeited. Sentencing of the individual is pending. She could receive up to 20 years in jail.

- A former VARO employee pled guilty to a one-count information, charging him with theft of public funds. A joint VA OIG and U.S. Postal Inspection Service investigation established the individual used his position to access VA's financial management system and caused the issuance of an out-of-system check for $29,208 under the name of an accomplice, who then cashed the check for him in return for $3,000.

Loan Guaranty Program Fraud

Loan Origination Fraud

- An individual was sentenced to serve 24 months' imprisonment, followed by 36 months' supervised release, and was ordered to make $87,603 in restitution to the Government. A joint investigation with the FBI and local law enforcement discovered the individual was the ringleader of a group of approximately 80 co-conspirators recruited to participate in a check fraud scheme. The scheme involved 16 fake business accounts opened to generate "payroll" checks made payable to the co-conspirators. The co-conspirators would cash these checks at local businesses and remit a portion of the proceeds back to the individual. During the investigation, it was discovered that the individual had submitted false statements to VA regarding his identification, employment, credit history, and financial transactions while trying to secure a loan to purchase a VA property. The VA loan was initially denied; however, the individual then submitted additional false statements and a counterfeit cashier's check in order to induce VA officials to reconsider his application. The application was later approved. After making only three payments, the loan went into default, resulting in a $16,817 loss to VA.

Other Loan Guaranty Fraud

- Three individuals were indicted on four counts of conspiracy to commit equity skimming and mail fraud. Between 1993 and 1999, two of the individuals operated a company that would contact homeowners who had defaulted on their current mortgages. Although they represented that they would pay the mortgages and other expenses relating to the properties, these individuals collected rental payments from tenants in these properties, but never paid off the mortgage on the property. Eventually the properties would go to foreclosure. In 1996, the third individual charged

in this scheme became employed in the business as an office manager. The investigation determined this scheme involved over 160 separate properties. Many of these properties were VA and Department of Housing and Urban Development (HUD) properties. The combined loss to the Government is currently over $1.4 million. This case is a joint investigation with the U.S. Postal Inspection Service.

- A husband and wife appeared in U.S. District Court for sentencing. The husband was sentenced to serve 34 months' imprisonment and 3 years' supervised probation upon release from prison and was ordered to pay restitution of $573,635. The wife was sentenced to 5 years' probation and ordered to pay restitution of $102,910. The sentencing was in response to a joint VA OIG, FBI, and HUD OIG investigation that developed evidence implicating the couple in a conspiracy with others to purchase and dispose of foreclosed VA and HUD properties in connection with a "flipping" scheme. As part of the scheme, the couple created fraudulent supporting documentation on a home computer that enabled unqualified buyers to obtain mortgage financing.

- A criminal information was filed charging an employee of a company with obstructing an agency proceeding. A joint agency investigation revealed that employees of the company had defrauded VA, HUD, and various financial institutions by submitting false and fraudulent information to the Federal Housing Administration, Government National Mortgage Association, and VA. Part of the scheme involved the defendants' obtaining loan proceeds from the corporation's warehouse lending institutions by submitting forged and fraudulent mortgages to those institutions as collateral for loans. The employee impeded the investigation by providing false information to federal agents. Losses in this case exceed $70 million.

Beneficiary Fraud

Dependency and Indemnity Compensation Benefits Fraud

- An individual pled guilty to theft of public monies. The joint VA OIG, FBI, and Social Security Administration (SSA), OIG investigation determined the individual's mother had died in January 1995. Prior to her death, she received both VA DIC and Social Security benefits. Absent notification of her mother's death, for the next 6 years both continued making monthly benefit deposits into her checking account. The joint investigation established that 2 years after her mother's death, the individual sent VA a fraudulent letter to which she forged her mother's signature. In late 2000, an ongoing VA OIG death match project confirmed her mother's death and also initiated the investigation against the individual. Combined Government monetary losses of $91,000 represented overpayments in VA and SSA benefits. Sentencing is pending.

Pension Benefits Fraud

- An individual was indicted on one count of theft of Government funds and one count of providing a false statement. The individual, a recipient of a death pension benefit based on her deceased husband's military service, failed to report her remarriage to VA over an 18-year period resulting in the receipt of $151,693 to which she was not entitled.

- The former spouse of a deceased veteran was indicted on six counts of theft of Government funds, two counts of making false statements to the Government, and two counts of mail fraud. The charges resulted from a VA OIG investigation that disclosed the individual collected VA widow's pension benefits since the death of her veteran husband in 1975. However, the individual remarried in 1976 and failed to notify VA. Her re-marriage made her ineligible to receive further

benefits payments. On annual VA eligibility verification forms, the individual reported to VA that she had not remarried since the death of her husband. Total loss to the Government is over $110,000.

Education Benefits Fraud

- A grand jury indicted two individuals for conspiracy and bribery of a public official. One individual, the executive vice-president of a college, was charged with one count of conspiracy and three counts of bribery. The other individual, the owner and president of the college, was charged with one count of conspiracy and one count of bribery. The indictment alleges the two individuals conspired to pay money to a VA vocational rehabilitation counselor (and a VA OIG undercover agent posing as a vocational rehabilitation counselor) in return for referring students to attend their college. It is also alleged that the individuals paid cash to the counselor in return for the referral of six students to attend their college.

Fiduciary Fraud

- A former VARO employee and a veteran's sister/guardian have been indicted for filing false statements in regards to the status of the veteran. The VARO employee made statements in his reports that he had personally interviewed the veteran at the veteran's mother's residence, when the veteran was actually serving a 4-year sentence in a penitentiary. Prior to the veteran's mother's death, the veteran's sister assisted the veteran's mother in falsifying the fiduciary account yearly reports, wherein they gave an accounting of the monies that they allegedly spent for the care of the veteran. They actually used the majority of the $92,400 for their personal use. This case is being jointly investigated with the FBI.

- An individual was sentenced to serve 12 months' home detention and 3 years' supervised probation, and ordered to pay $490,625 in restitution. The individual previously pled guilty to four counts of misappropriation by a fiduciary after a joint VA OIG and SSA OIG investigation substantiated allegations that he had embezzled over $400,000 from the estates of veterans for whom he had been appointed conservator.

Theft of Benefits

- The daughter of a deceased veteran was sentenced to 3 years' probation and ordered to pay $1,800 in restitution. The individual had previously pled guilty to two counts of theft of Government property/funds. The VA OIG investigation determined the daughter failed to report to VA the death of her father and submitted several forged documents to VA indicating her father was still alive. The daughter deceived the VA for over 20 years resulting in an overpayment exceeding $497,000.

- The granddaughter of a deceased widow who had been receiving VA benefits was sentenced to serve 6 months' home confinement and 5 years' probation, and to make restitution of $33,171. The grandmother died in March 1982, and VA was not notified of the death. Benefits continued to be paid through March 2000, creating an overpayment of $148,652. Investigation disclosed the widow's daughter had negotiated the majority of benefits, but was of such debilitating physical condition that prosecution was precluded. Following the daughter's hospitalization in 1996, the granddaughter continued the negotiation of the widow's benefits.

Philippines Benefits Fraud

- The OIG conducted a proactive investigative project based on suspected fraud associated with the delivery of benefits to veterans residing in the Philippines. A team of OIG employees conducted the review that consisted of mailing over 20,000 letters, conducting 1,100 face-to-face interviews, performing 2,400 fingerprint comparisons, and reviewing 2,500 VA claim folders. These actions resulted in the proposed termination from VA

VA Secretary Anthony J. Principi and IG Richard J. Griffin observe the Phillipines fraud review work in progress. From l to r are Secret Service fingerprint analyst Jim Price, VARO Assistant Director Jon Scully (rear), Secretary Principi, OIG Criminal Investigations Division Director James Gaughran, Mr. Griffin, and OIG Program Manager Debra Crawford.

benefit rolls of almost 600 payees. To date, the cost savings to VA is over $2.5 million in overpayments with a projected 5-year cost savings of over $21 million by terminating VA payments of those individuals who are not entitled to the benefits. Nine criminal cases were initiated and 15 individuals have been arrested. These cases were investigated and referred to the Philippines National Bureau of Investigation. One of these cases involved a large criminal organization that was involved in submitting claims to VA on behalf of potential beneficiaries. The organization would often submit false documentation to VA in support of the claim. Based on evidence developed by the VA OIG, an undercover operation was conducted on this case and evidence of the crimes was collected using a search warrant. The two ringleaders of this organization were among those arrested. Additionally, 147 other subjects have been identified as having been involved in this scheme.

Other Benefits Fraud

- A former state employee, who also served as a national service officer for a veterans' service organization, was sentenced to serve 4 months' incarceration and 1 year supervised probation, and was ordered to pay $101,882 in restitution. The court also banned the individual from representing veterans before the VA. The individual previously pled guilty to one count of unlawful receipt of funds from veterans. A joint investigation conducted by the VA OIG and FBI revealed that between 1996 and 2001, the individual received approximately $300,000 in illegal payments while representing 250 former prisoners-of-war veterans from World War II and the Korean War. The VA terminated the individual's accreditation as a service officer. The individual resigned from employment with the state shortly before entering the guilty plea.

- A husband and wife both pled guilty to making a false statement and misusing of a Social Security number to commit fraud. The defendants admitted they fraudulently obtained $31,222 in benefits from the Government by concealing employment and making false reports. The individuals also passed two counterfeit U.S. Treasury checks at a bank. One was a $25,000 counterfeit check purportedly issued by SSA and the other was a $250,000 counterfeit check purportedly issued by VA.

Fugitive Felon Program

The Office of Investigations has established a Fugitive Felon Program to identify VA benefits recipients who are fugitives from justice. The program is still under active development and will include conducting computerized matches between fugitive felon files of law enforcement organizations and VA files of veterans who have received benefits from VA. Once identified as fugitives, information on the individuals will be provided to law enforcement organizations to assist in apprehension. Ultimately, fugitive information will be provided to VA to suspend benefits payments and initiate recovery action. Two recent investigations dealing with fugitives are detailed below.

- VA police contacted the VA OIG for assistance concerning an inpatient at a VAMC. The inpatient had an outstanding warrant for his arrest for a recent 1st degree assault during which the veteran slashed the throat of his girlfriend. The warrant was an out-of-state warrant, thus a fugitive warrant was obtained. Investigation disclosed the veteran had admitted himself into the VAMC psychiatric unit after the alleged assault. VAMC psychiatrists advised the veteran was competent to understand the charges against him, and the VAMC planned on discharging him that same day. VAMC staff reported that the veteran, a former member of the motorcycle gang, asked questions about the VA police, such as "do they carry guns and what kind of guns?" VAMC staff also reported the veteran stated that he would not return to jail. VA police and VA OIG agents apprehended the veteran without incident. Bail was set at $50,000 and the veteran was transported to the county jail to await his arraignment.

- A Federal arrest warrant has been obtained for a veteran for unlawful flight to avoid prosecution. The issuance of the arrest warrant was the result of a joint investigation with the FBI that concluded the veteran, wanted for 2nd degree manslaughter, 3rd degree assault, and reckless driving had fled in order to avoid prosecution for these offenses. In this case, a 10-year-old girl was killed and her mother was seriously injured allegedly because of the veteran's reckless driving. The VA OIG provided the recent addresses for the suspect. A court order has been obtained ordering the bank to disclose on a daily basis the banking activity, including automated teller machine withdrawals, in an effort to apprehend this fugitive. The veteran is currently receiving $2,163 per month in VA benefits due to a 70 percent post-traumatic stress disorder disability. At this time, the VA benefits will not be cut off under the provisions of the new fugitive felon initiative, as the veteran's automated teller machine withdrawals may lead to his apprehension.

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, typewriting analysis, ink and paper analysis, analysis of photocopied documents, and suspected alterations of official documents.

There were a total of 34 reports issued involving 23 completed laboratory cases during this semiannual period.

Laboratory Cases for the Period

Requester	Cases Completed
OIG Office of Investigations	8
VA Regional Offices	13
Office of Security and Law Enforcement	1
Other	1
Total	**23**

The following are examples of completed laboratory reports:

- A laboratory examination determined that an individual forged the signature of a veteran's fiduciary on a letter sent to VA in support of benefits payments. The individual when confronted with the evidence in court stipulated to the forgery and was subsequently found guilty for making false statements. The loss to VA in this case was over $90,000.

- In another case, a veteran submitted ballpoint ink handwritten medical records to VA for service-connected benefits. Laboratory

examinations determined the ink used in the medical records had not been manufactured on the dates recorded on the documents.

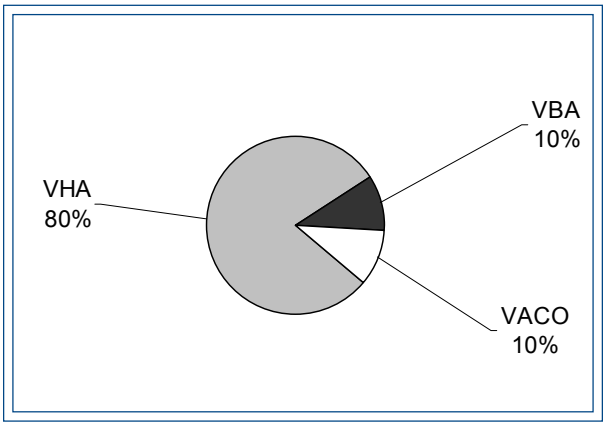
II. ADMINISTRATIVE INVESTIGATIONS DIVISION

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

- We closed 27 cases.
- We issued five reports (including two from a single case) and eight advisory memoranda. Fifteen cases resulted in administrative closures.

Outcome

- VA managers agreed to take administrative sanctions against two officials, and take six corrective actions to improve operations and activities, as a result of these investigations. The corrective actions included correcting an improper personnel action, clarifying and taking steps to ensure adherence to certain Federal ethics regulations, and charging a physician leave for time not worked.

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

VETERANS HEALTH ADMINISTRATION

Physician Time and Attendance

- An administrative investigation substantiated that a full-time physician misused his official VA duty time by working for compensation at the affiliated medical school during his regular VA tour of duty. The investigation disclosed that, over a 12-month period, the physician treated patients at the affiliate on 20 days during his VA tour of duty. VHA took appropriate administrative action against the physician and charged him 20 days of annual leave.

Acceptance of Pharmaceutical Samples

- An administrative investigation disclosed that a medical center pharmacy chief misused his position and improperly accepted gifts of pharmaceutical samples on multiple occasions. The pharmacy chief solicited and accepted medications from representatives of pharmaceutical companies for his personal use and the use of his family members. The medical

center director took administrative action against the chief. The director also drafted a local policy prohibiting pharmaceutical company representatives from giving drug samples to staff. In response to recommendations to VA Central Office on this issue, officials issued a statement to field employees explaining the Federal ethics regulations concerning acceptance of gifts, and worked with the Office of General Counsel on more specific guidance.

Cleanliness and Sanitation Conditions

- An administrative investigation determined whether senior executives at a co-located VISN and VAMC were aware of cleanliness and sanitation conditions at the medical center, provided effective leadership to improve those conditions, and intentionally misled the Office of the Secretary regarding the facility's current status. The investigation concluded that the VISN director and deputy director were aware of the cleanliness conditions and should have intervened more aggressively to ensure the deficiencies were addressed. The deficiencies were a result of the former medical center director's decision to give funding priority to construction projects and staffing needs that more directly related to quality of care and patient satisfaction rather than to housekeeping. The VISN director and deputy director were aware of these priorities. The investigation also concluded that the VISN director and current medical center director did not intentionally mislead the Office of the Secretary regarding current cleanliness conditions at the facility, although some of the information they provided could have been interpreted to suggest that broader cleanliness and sanitation issues had been resolved. We provided the investigation report to the Secretary of Veterans Affairs for his information and whatever action he deemed appropriate.

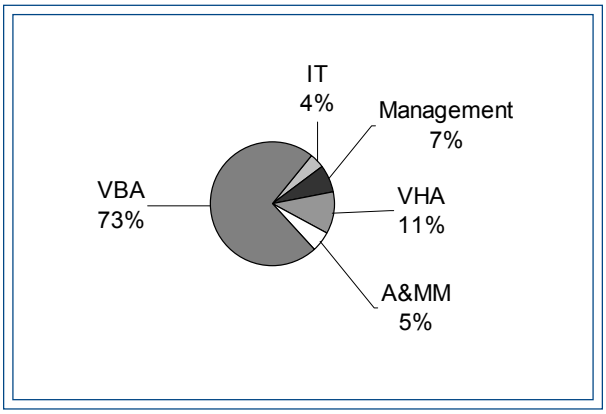
OFFICE OF AUDIT

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 24 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 37 audits, evaluations, and reviews for an output efficiency of 1 report per 2.4 FTE during this 6-month period. We also issued an additional 29 contract review reports (18 preaward and 11 postaward contract reviews), for an output efficiency of about 2.4 reports per FTE for the 6-month period.

Outcome

- Recommendations to enhance operations and correct operating deficiencies have associated monetary benefits totaling approximately $190.9 million. In addition, contract reviews identified monetary benefits of about $36.7 million associated with the performance of preaward and postaward contract reviews.

Cost Effectiveness

- We achieved a return of about $16 in monetary benefits for every dollar spent on audits, evaluations, and reviews during this 6-month period. We also achieved a return of about $27 in monetary benefits for every dollar spent on contract reviews. Additionally, contracting officers sustained 67 percent of our recommended better use of funds during negotiations.

Customer Satisfaction

- Customer satisfaction with performance and financial audits and evaluations during this reporting period was 4.5 on a scale of 5.0. The average customer satisfaction rating achieved for contract reviews was 4.8 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. The following summarizes some of the audits completed during the reporting period organized by VA component: VHA, VBA, and Office of Management.

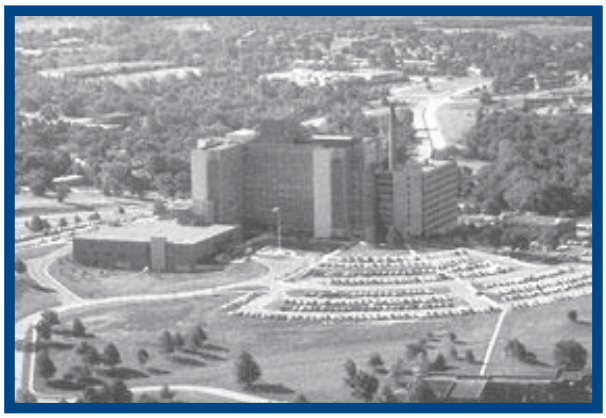
Veterans Health Administration

Quality of Care

Issue: Medical center sanitation.
Conclusion: Management did not maintain appropriate levels of cleanliness or rid the center of pests.
Impact: Strengthened controls to monitor the quality of care provided to patients.

At the request of the Secretary of Veterans Affairs, we conducted a review of the sanitation and pest control at Kansas City VA Medical Center. We found that management did not maintain the medical center at appropriate levels of cleanliness or rid the medical center of pests. The unclean conditions date back to at least October 1997; were discussed among medical center management, staff, and patients; and were well documented in medical center records. Management of the Heartland Veterans Integrated Service Network (VISN 15) was also aware of the poor sanitary conditions and pest control at the VAMC.

VAMC clinical management implemented effective controls to monitor the quality of care provided to patients as the controls related to infectious diseases and infection control. We also found that the care provided to the two patients discussed in an article entitled, "Nasal Myiasis in an Intensive Care Unit Linked to Hospital-Wide Mouse Infestation" was adequate, but that the incidents described occurred because of poor insect control at the facility.



VA Medical Center
Kansas City, MO

The Secretary of Veterans Affairs, the Under Secretary for Health, the Assistant Deputy Under Secretary for Health, and the Medical Center Director concurred with the recommendations made to them and provided acceptable implementation plans for all applicable recommendations. *(Report on Medical Center Sanitation and Follow-up of the Combined Assessment Program Review Kansas City VAMC, 02-02280-112, 6/3/02)*

Resource Utilization

Issue: Management of miscellaneous supply inventories.
Conclusion: VAMCs could reduce linen inventories by using automation and establishing a 3-day supply goal, and could reduce all miscellaneous supply inventories by complying with VHA's policy.
Impact: Potential better use of $54 million.

The VA OIG performed an audit to evaluate how effectively VAMCs managed their miscellaneous supply inventories. This was the fifth in a series of audits that the OIG has performed to assess inventory management practices for various categories of supplies. There are four categories of miscellaneous supplies: operating supplies (mainly housekeeping and dietetic items), office supplies, employee uniforms, and linens. In FY 2001, VHA's miscellaneous supply purchases totaled $236 million. At any given time during FY 2001, the value of VAMC miscellaneous supply inventories was $69 million.

Our audit of inventory practices at four representative VAMCs found that all four had

operating, office, and uniform supply inventories that exceeded the 30-day level. We used a 3-day supply level as the criterion for evaluating linen inventory management because these items are reusable. All four of the VAMCs audited had linen inventories that substantially exceeded the 3-day criterion. The four VAMCs had combined miscellaneous supply inventories valued at $3.5 million, $2.7 million (77 percent) of which was excess.

The excess inventories occurred primarily because VAMC inventory managers did not effectively use VA's automated Generic Inventory Package (GIP) to control inventory levels. Of the 16 inventories reviewed, 6 were managed and 10 were not managed with GIP. At the VAMCs where GIP was used, inventory managers had not taken full advantage of GIP's capabilities and had excess inventory on hand.

VAMC compliance with the requirements of VHA's inventory management handbook will address the issue of using GIP to properly manage operating, office, and uniform supply inventories. However, to improve linen inventory management, we recommended that VHA ensure that Textile Care Management Report guidance: (i) requires VAMCs to use GIP to manage linen inventories; and (ii) establishes goals for reducing linen inventory levels, with a 3-day level as the initial goal and a 1-day level as the ultimate goal. We estimated that better management could reduce VHA-wide miscellaneous supply inventories by $54 million. The Under Secretary for Health agreed with the audit findings and recommendations and provided acceptable implementation plans. *(Audit of VAMC Management of Miscellaneous Supply Inventories, 00-01089-91, 5/8/02)*

Issue: VA Consolidated Mail Outpatient Pharmacies (CMOPs) inventory management.

Conclusion: VA CMOPs could reduce pharmaceutical inventories by effectively using automated inventory controls and developing better reports.

Impact: Potential better use of $29 million.

The OIG performed an audit to evaluate how effectively VA's seven CMOPs managed their pharmaceutical inventories. In FY 2001, CMOP expenditures for pharmaceuticals totaled $1.4 billion and the combined CMOP inventories totaled about $64 million.

Our audit found that CMOPs could significantly reduce their pharmaceutical inventories. In evaluating inventory levels, we applied three different benchmarks for the three major types of items in inventory-ready-to-dispense items (10-day supply level), repackaged items (30-day level), and bulk quantity items (14-day level). The supply on hand exceeded the applicable benchmarks for 11,553 (60 percent) of the 19,276 items in the CMOP inventories. We estimated that of the $64 million in total inventory at the seven CMOPs, $29 million (45 percent) exceeded current operating needs.

The excess inventory occurred because CMOP staff did not closely monitor stock levels, made unnecessarily large purchases, and did not effectively manage item demand. These problems could have been avoided or minimized if CMOPs had more effectively used the inventory management features and data available in their automated systems. CMOPs also needed to develop better inventory management reports that would help them monitor stock levels and identify out-of-line situations such as excess inventory. In addition, one CMOP had not effectively implemented controls to ensure the security and accountability of its controlled substances inventory.

We recommended that VHA: (i) require CMOPs to eliminate excess inventories and to effectively use automated inventory information; (ii) improve automated inventory management reports; (iii) develop minimum demand requirements for adding new products; (iv) train CMOP staff on inventory management techniques and the use of automation; (v) ensure that CMOPs implemented effective internal controls and security requirements for controlled substances; and (vi) monitor CMOP progress in reducing inventories and improving inventory management. The Under Secretary for Health agreed with the findings and recommendations and provided acceptable implementation plans. (*Audit of VA Consolidated Mail Outpatient Pharmacy Inventory Management, 00-01088-97, 5/17/02)*

Data Validity

Issue: Compliance with Public Law 107-135.
Conclusion: With the exception noted, VA's Special Disabilities Capacity Report fairly and accurately presents the data required by the Public Law.
Impact: Accurate data.

The purpose of the audit was to determine if the VA's FY 2001 Special Disabilities Capacity Report accurately presents the information required by statute. The audit was conducted to comply with the VA Health Care Programs Enhancement Act of 2001 (Public Law 107-135) that requires the OIG to audit each annual capacity report and submit a certification to Congress as to its accuracy.

With the exception of five data tables involving mental health program staffing, we concluded that VA's FY 2001 Special Disabilities Capacity Report fairly and accurately presents the staffing, workload, costs, and other data required by the Act. During the course of the audit, we issued an Advisory Letter to VHA program officials outlining the staffing data reporting deficiencies. The Under Secretary for Health provided a response to the Advisory Letter that agreed with the audit results and discussed actions VHA will take to address the identified deficiencies. Based on the Under Secretary's planned actions, no recommendations were included in the report. *(Audit of Department of Veterans Affairs Fiscal Year 2001 Special Disabilities Capacity Report, 02-01202-164, 9/12/02)*

Veterans Benefits Administration

Delivery of Benefits and Services

Issue: Unreimbursed medical expense (UME) claims.
Conclusion: Beneficiary claims for unreimbursed medical expenses are at risk for errors and fraud.
Impact: Potential better use of $125 million.

At the request of the former Under Secretary for Benefits, who was concerned about potential program fraud, the OIG conducted an audit of VBA's benefit payments to beneficiaries receiving increased benefits as a result of UME claims. The purpose of the audit was to determine the accuracy of the award and support for beneficiary UME claims.

The audit found that beneficiaries were inappropriately submitting UME claims that increased the level of their benefit payments. Processing of these claims was not effectively handled by VBA, resulting in processing errors and potential program fraud with a significant number of erroneous benefit payments to claimants (both overpayments and underpayments). Also, VBA needs to enhance the effectiveness of its verification of UME claims under the Provider Proof Verification program and ensure that the higher cost claims (UME claims over $15,000) are verified. Processing errors and potential program

fraud results in annual beneficiary overpayments of as much as $125 million and underpayments totaling as much as $20 million. These processing errors and potential program frauds represent significant potential lifetime overpayments and underpayments to beneficiaries. The Under Secretary for Benefits agreed with the report findings, and provided acceptable implementation plans that address the intent of the recommendation. *(Audit of VBA Benefit Payments Involving Unreimbursed Medical Expense Claims, 00-00061-169, 9/30/02)*

Office of Management

VA's Consolidated Financial Statements

Issue: Financial management.
Conclusion: Management letters were issued to assist VA in improving financial management.
Impact: Improved financial reporting and controls.

The independent public accounting firm, Deloitte & Touche LLP, performed VA's Consolidated Financial Statements (CFS) audit for the OIG. As part of the audit, we issued five management letters addressing financial reporting and control issues. The management letters provided VA managers additional observations and advice that will enable the Department to improve accounting operations and controls.

One management letter (Report No. 01-01463-123): (i) reiterates the six material weaknesses and five reportable conditions identified in our previously issued CFS audit report No. 01-01463-69 (Audit of the Department of Veterans Affairs Consolidated Financial Statements for FYs 2001 and 2000, February 27, 2002); (ii) provides 19 additional observations and recommendations from the audit to further assist the Department in improving internal controls and financial reporting; and (iii) shows the results of the follow up of prior year CFS audit findings. The other four management letters covered the three data centers and one application system and were issued on a limited basis.
[(i) Management Letter, Audit of VA's FYs 2001 and 2002 CFS General Systems Control Review at the Austin Automation Center, 01-01463-104, 6/3/02;
(ii) Management Letter, Audit of VA's FYs 2001 and 2002 CFS General Systems Control Review at the Hines Benefit Delivery Center, 01-01463-106, 6/13/02;
(iii) Management Letter, Audit of VA's FYs 2001 and 2002 CFS General Systems Control Review at the Philadelphia Information Technology Center, 01-01463-105, 6/13/02;
(iv) Management Letter, Audit of VA's FYs 2001 and 2002 CFS Loan Guaranty Systems Control Review at the Austin Automation Center, 01-01463-107, 6/13/02;
(v) Management Letter, Audit of VA's CFS for the FY Ended September 30, 2001, 01-01463-123, 6/21/02]

Preaward Contract Reviews

Issue: Federal Supply Schedule (FSS) vendors' best prices.
Conclusion: Vendors can offer better prices to VA.
Impact: Potential better use of $28 million.

Preaward reviews of 12 FSS and direct delivery offers contained recommendations that have the potential for cost savings of $28 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: Healthcare resource contracts.
Conclusion: VA can negotiate reduced contract costs.
Impact: Potential better use of $5 million.

We completed reviews of six proposals from VA affiliated medical schools involving the acquisition of scarce medical specialists' services. We concluded that the contracting officer should negotiate reductions of $5 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: Postaward reviews disclosed overcharges.
Impact: Recovery of $4 million.

- We completed two Public Law 102-585 compliance reviews at pharmaceutical vendors, with recoveries amounting to $62,000.

- We completed nine reviews of vendors' contractual compliance with specific pricing provisions of their FSS contracts. Recoveries amounted to $4 million.

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

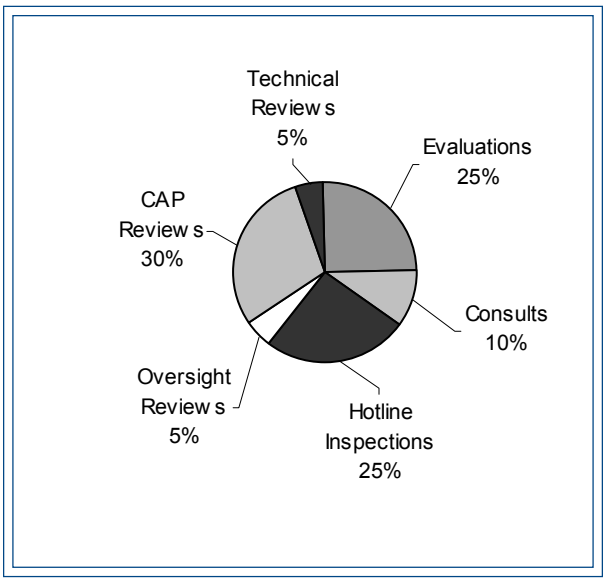
OFFICE OF HEALTHCARE INSPECTIONS

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 healthcare 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, oversight and technical reviews; and clinical consultations for support of criminal cases.



Overall Performance

Output

Inspectors completed 195 initiatives for an output efficiency of 8 initiatives per allocated FTE in OHI during this reporting period.

- We participated in 18 CAP reviews to evaluate healthcare issues and made 111 recommendations that will improve operations and activities, and the care and services provided to patients.

- At the request of the Secretary of Veterans Affairs, we participated in one follow up CAP review on actions taken to implement recommendations reported during the last semiannual report. The review included 12 recommendations to improve the quality of care, sanitation, control over pest infestations, and infection controls.

- We completed reports on 2 summary evaluations and made 8 recommendations to enhance VHA's pain management initiatives and procedures for prescribing mental health patients controlled substances.

- We completed reports on 20 Hotline cases, which consisted of reviews of 69 issues, and we made 57 recommendations that improve the health care and services provided to patients.

- We monitored the completion of another 99 Hotline cases. These cases, consisting of allegations pertaining to 136 issues, were referred to VHA managers for actions.

- We provided clinical consultative support to investigators on 6 criminal cases.

- We completed 28 technical reviews on recommended legislation, new and revised policies, new VA program initiatives, and external draft reports.

- We administratively closed 4 Hotline cases because the allegations were not substantiated.

- We oversaw the work of VHA's Office of the Medical Inspector on 3 projects.

Outcome

- Overall, we made or monitored the implementation of 188 recommendations 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 plans will improve clinical care delivery, management efficiency, and patient safety and will hold employees accountable for their actions.

Customer Satisfaction

- We surveyed the facilities visited and asked for their input concerning the benefits of our inspections. Survey results showed an average rating of 4.7 out of a possible best score of 5.0.

Veterans Health Administration

Summary Evaluations

Issue: Prescribing long-term controlled substances for mental health patients with chronic pain.
Conclusion: Care could be improved by better managing narcotics prescribed for patients.
Impact: Effective management of patients' chronic pain.

We conducted a review of prescribers' management of long-term controlled substances usage for mental health and behavioral sciences patients. Controlled substances are psychoactive drugs, including narcotics, that have abuse potential and the ability to produce dependence.

We concluded that the quality of care in VHA mental health programs could be improved if there were more consistency among providers in managing long-term narcotics for patients who have pain. Prescriptions of narcotics for long-term pain control in mental health patients were not consistently justified in medical records. Psychiatrists inconsistently considered or documented referrals to alternative treatment modalities such as pain clinics. Additionally, clinical reasons for prescribing narcotics and treatment contracts with patients were not regularly evident in the records we reviewed.

We made three recommendations that will strengthen the procedures for managing mental health patients who have chronic pain. The Under Secretary for Health agreed with the findings and recommendations, and provided acceptable implementation plans. *(Healthcare Inspection - Controlled Substances Prescribed to Patients in VHA Mental Health and Behavioral Sciences Programs, 01-00026-18, 4/16/02)*

Issue: VHA's pain management initiative.
Conclusion: Opportunities exist to strengthen VHA's pain management program.
Impact: Enhance the effectiveness of VHA's controls and procedures for managing patients' pain.

This review was conducted to evaluate VAMCs' compliance with VHA's pain management initiative. We examined current facility policies on pain management, employee pain management education, the effect staff attitudes and facility cultures had on pain management practices, and the adequacy of assessment and treatment information documented in medical records.

We found that VHA has made significant strides in implementing and enhancing managers' knowledge of the initiative, but as with any new initiative, more work needs to be done. We found that managers had implemented the 5th vital sign initiative at the sites visited, but the extent of implementation varied. Some facilities had not formalized policies or plans for pain management, and others had only draft policies. At four sites, nursing or medical employees assessed patients for pain in the outpatient settings, but there was no documentation that patients who reported pain

were subsequently assessed during their hospital stays. On the other hand, some facilities had established pain management clinics, provided widespread education and training, and appointed unit-based pain management liaisons who regularly assessed patients' pain treatments.

We made five recommendations to strengthen VHA's pain management initiative. The Under Secretary for Health concurred with our recommendations and provided acceptable implementation plans. *(Healthcare Inspection - VHA Pain Management Initiative, 01-00026-101, 6/10/02)*

Healthcare Inspections

Issue: Anesthesia care.
Conclusion: Clinicians did not meet the standards of care in two of five cases reviewed.
Impact: Improved policies and procedures for anesthesia care.

We received a request from the Secretary of Veterans Affairs to review allegations of substandard anesthesia care. The allegations concerned the anesthesia care administered to five patients who expired. In two of the five cases, we found the anesthesia care did not meet accepted standards of medical practice.

The anesthesiologist involved in one case resigned from the VA health care system in early 2002 for unrelated reasons. The anesthesiologist involved in the second case received disciplinary action, and senior managers reviewed the cases to ensure compliance with incident reporting requirements. However, we found that senior managers needed to inform the surviving families of the circumstances surrounding the patients' deaths in accordance with prescribed VA policies. We also found that the certified registered nurse anesthetist (CRNA) credentialing and privileging process at the health care system was not consistent with VHA guidelines. We substantiated an allegation that

Southern Arizona VA Health Care System
Tuscon, AZ

CRNAs were not supervised in the pain clinic as required by VHA policy.

We made three recommendations to the VISN Director. The VISN Director concurred with the recommendations and agreed to notify the families of the circumstances surrounding the patients' adverse outcomes, modify the facility's credentialing and privileging process to fully comply with VHA policies, and instruct surgical line leaders on the appropriate CRNA scope of practice. (*Healthcare Inspection - Patient Anesthesia Care Issues, Southern Arizona VA Health Care System, Tucson, AR, 02-02121-159, 9/03/02)*

Issue: Quality of radiology care.
Conclusion: Actions were needed to address documentation deficiencies.
Impact: Improved documentation of the care provided to patients receiving radiology procedures.

We received a patient complaint alleging that a VAMC radiologist was unable to discern a brain aneurysm (a weak spot in the blood vessel that could rupture and lead to brain damage or death) from computerized axial tomography (CAT) scan films. It was alleged that this inaccurate interpretation delayed the patient's diagnosis and treatment, and put his life at risk. He alleged that other professionals who were given copies of the

CAT scan easily detected the abnormality. He also complained that a VAMC neurology consultant made seven attempts over a 15-minute period, but was unable to perform a successful lumbar puncture (a procedure wherein a sterile needle is inserted into the lower spine to collect cerebrospinal fluid for diagnostic purposes). The complainant asserted that he received substandard care at the VAMC; as a result, he suffered a ruptured brain aneurysm that required his admission to two non-VA hospitals.

We concluded that the complainant received appropriate evaluation and treatment based on the results of the March 20, 1999 cranial CAT scan and the neurologist's March 24 findings. A cranial arteriogram performed by private sector physicians on April 4, after the patient experienced a ruptured aneurysm, showed that the rupture occurred in an area of the brain that three different radiologists and a neurologist felt was normal on the March 20 CAT scan. We found no evidence that the radiologist misinterpreted the complainant's CAT scan, resulting in delayed diagnosis or treatment. We substantiated the allegation that the VAMC neurology consultant did not successfully obtain spinal fluid after a difficult lumbar puncture, but there was no way to speculate whether the complainant's outcome would have been different had clinicians continued efforts to obtain spinal fluid. The VAMC neurology consultant followed applicable standards of care in this case. The VAMC Director took administrative action to address documentation deficiencies found during a peer review. Thus, we did not make any recommendations. *(Healthcare Inspection - Patient Care Issues, William Jennings Bryan Dorn VAMC Columbia, SC, 02-00824-95, 5/07/02)*

William Jennings Bryan Dorn VA Medical Center
Columbia, SC

Issue: Cardiac surgery complication and over-sedation.

Conclusion: Further review of a patient's care was needed.

Impact: Strengthened procedures to guard against over-sedating patients.

The Senate Committee on Veterans' Affairs asked us to conduct an inquiry into the quality of care received by a patient at the VAMC, particularly as it pertained to events surrounding cardiac procedures performed on June 6, 2001. Specifically cited as concerns were an alleged puncture of one of the patient's coronary arteries during a cardiac catheterization procedure resulting in cardiovascular collapse, brain injury due to lack of oxygen, and death 5 days later. The complainants also alleged: delayed recognition of the complication of coronary artery perforation; substandard interventional cardiac care at the VAMC; lack of due consideration of a patient's wishes regarding terminal care; premature attempts at a patient out-placement; and over-sedation of a patient.

We confirmed that during the course of coronary angiography, followed by sequential coronary angioplasty, the patient's right coronary artery was perforated. This is a rare and catastrophic event, but nonetheless well-known complication of this procedure. Even in the best of circumstances, the morbidity and mortality resulting from this major complication is high. VAMC quality management employees and clinicians participating in a morbidity and mortality conference appropriately reviewed the case.

We did not substantiate the allegation that the patient's wishes not to be placed on a ventilator were disregarded. We also did not substantiate the allegation that there was an inappropriate or premature attempt to transfer the patient to a nursing home. We confirmed that a second patient was over-sedated at the onset of his VAMC admission, but the evidence does not show a clear nexus between the over-sedation and the patient's outcome. Pending receipt of a satisfactory peer review by VAMC clinical staff of the care provided to this patient, we will determine whether further action is necessary, or we will close the case. Since the Director agreed to order a peer review of the second patient's treatment, emphasizing the appropriateness of narcotics analgesics usage, we did not make any recommendations. OHI will oversee and evaluate the rigor of the peer review when it is completed. (*Healthcare Inspection - Patient Care Issues, Richard L. Roudebush VAMC Indianapolis, Indiana, 01-02863-98, 5/08/02)*

Issue: Customer service and quality of medical care.
Conclusion: Actions were needed to improve the overall quality of clinic customer services.
Impact: Improve care and services for outpatients.

We received congressional and local stakeholder inquiries concerning the quality of customer service and personnel matters at the Prestonsburg community-based outpatient clinic, which is an organizational component of VAMC Huntington, WV. Complainants made numerous allegations concerning the adequacy and quality of customer services, and the medical care provided at the clinic. Complainants also alleged that clinic managers took inappropriate actions against employees who patients believed were attempting to provide good customer service.

We confirmed that VAMC managers needed to improve the overall quality of clinic customer services for veterans and their family members. Managers had initiated actions to address some of the complaints, but additional actions were needed to improve outreach efforts, the quality of physician communication with patients, and narcotic dispensing procedures. Managers also needed to monitor the timeliness of providing care for patients who walk in and those who have scheduled appointments. They also needed to review the feasibility of using local vendors to provide certain radiology services for patients not able to travel to the parent VAMC.

We did not substantiate the allegation that newly prescribed medications mailed to patients were excessively delayed, but we found that new procedures were delaying deliveries of prescribed narcotics. We did not substantiate the allegations that procedures and consultations were administratively cancelled, that patients paid for private medical services when services were not available at the clinic, or that managers had not attempted to increase specialty services or clinic hours of operation. Finally, we did not substantiate the allegations that two part-time physicians were inappropriately discharged.

We made six recommendations to improve the quality of services. The VAMC Director agreed with the findings and recommendations and provided acceptable implementation plans. *(Healthcare Inspection - Customer Service and Personnel Matters at the Department of Veterans Affairs VA Community-Based Outpatient Clinic, Prestonsburg, KY, 02-00249-100, 5/14/2002)*

VA Medical Center
Perry Point, MD

Issue: Quality of intermediate medical care.
Conclusion: Managers needed to address consultation procedures, safety issues, and nurse utilization.
Impact: Better care and services for patients.

We received a request from the Chairman of the House Committee of Veterans' Affairs, Oversight and Investigations Subcommittee, to review allegations of inadequate intermediate medical care provided to patients. A complainant alleged that a patient on the intermediate medicine unit was denied physical therapy. The complainant also alleged that the patient received inadequate nursing care, improper wound care, and the wrong eyeglass prescription, and that the unit did not have sufficient nurse staffing to care for all the patients. The complainant further alleged that another patient fell out of bed and eventually died because of nursing inattention.

We concluded that the patient did not receive physical therapy services in a timely manner, because clinicians had not communicated consultative recommendations effectively. Managers enhanced the hospital's computerized patient record system to alert physicians when consultations are completed. We also found that the ramp to the outside smoking facility was a safety hazard for mobility-impaired patients. The Director concurred and issued a work order to widen the ramp and eliminate the drop off. The unit had a sufficient number of nursing employees; however, nurse staffing levels needed adjustment to ensure adequate staffing on all three tours of duty. Managers were adjusting staffing levels to ensure all tours of duty had adequate nursing support.

An optometry resident improperly measured bifocal lenses for the patient's eyeglasses, but this had been corrected before our site visit and resident supervision had improved. We did not find any indication that the other patient died because of nurse inattentiveness. Since managers had already corrected or were in the process of correcting identified problems, we did not make any recommendations. *(Healthcare Inspection - Quality of Care Issues, Department of Veterans Affairs Health Care System, Perry Point, MD, 02-01331-110, 6/03/02)*

Issue: Quality of ophthalmology care.
Conclusion: Action needed to address a clinician's communication skills.
Impact: Better customer service.

A complainant alleged he received questionable and delayed medical treatment when a VA ophthalmologist changed his previous diagnosis and did not schedule cataract surgery. The complainant also alleged that the ophthalmologist was unprofessional, rude, and threatened to change his disability rating.

We did not substantiate the allegations that the complainant received questionable and delayed medical treatment. However, we concluded that action needed to be taken to address the ophthalmologist's communication skills. Also, based on the ophthalmologist's assessment, the question of the patient's continued disability for visual impairment needs to be resolved.

We recommended that appropriate action be taken to improve and monitor the ophthalmologist's communication with patients, and an impartial ophthalmologist review the complainant's medical condition and work through the established compensation and pension process to determine continued eligibility for benefits. The Director agreed with the findings and recommendations, and provided acceptable implementation plans. *(Healthcare Inspection - Quality of Care Issues, VA Healthcare System, El Paso, TX, 02-0838-118, 6/12/02)*

VA Healthcare System
El Paso, TX

Issue: Patient abuse, employee misconduct, and patient safety violations.
Conclusion: Certain nursing staff did not maintain standards of ethical conduct.
Impact: Improved effectiveness of unit's management and improved care and services.

We performed this inspection in response to inquiries from congressional representatives to determine the validity of allegations of patient abuse, employee misconduct, and patient safety violations. The complainant made several allegations concerning a charge nurse on an extended-care unit, including that the nurse had: (i) treated patients abusively by withholding meal trays and yelling at patients; (ii) over-sedated a patient; and (iii) compromised patient safety protocols by assigning one nurse to administer all patient medications. The complainant listed additional concerns about the competency of the charge nurse. The complainant alleged that the unit's nurse manager had taken soft drinks from a patient's personal refrigerator without his permission on several occasions, and demanded that nurses interrupt their administration of medications to speak with her. The complainant also alleged that both the charge nurse and the unit nurse manager had jeopardized patient safety by being excessively absent from the unit to take smoking breaks.

We concluded that the charge nurse and the nurse manager did not maintain the standards of ethical conduct required of employees with supervisory and patient care responsibilities.

We found evidence of verbal abuse and patient neglect, a disregard for policies and procedures, and harassment of employees. In our opinion, the subjects' apparent disregard for customer service standards compromised patient safety and reduced the morale of employees under their supervision. In addition to creating a hostile work environment for employees, this situation adversely affected patient care. Responsible supervisors did not take sufficient actions in response to: (i) feedback from patients, families, and employees regarding both nurses' behaviors; (ii) the management practices of the nurse manager; and (iii) deficiencies in documentation and patient care on the unit. Both subjects continued to receive highly satisfactory performance appraisals despite mounting evidence of their performance deficiencies and mismanagement, and the impact of these deficiencies on patients and staff.

We made six recommendations to improve the effectiveness of the unit's management and ensure high-quality patient care. The Director concurred with the recommendations and provided acceptable

implementation plans. *(Healthcare Inspection - Patient Treatment and Employee Conduct Issues, Central Arkansas Veterans Healthcare System, Little Rock, AR, 02-00705-121, 6/13/02)*

Issue: Unexpected patient death.
Conclusion: Managers needed to consistently apply monitoring procedures to ensure patients are safe.
Impact: Improved search procedures.

In response to a congressional inquiry, we conducted a review of the issues and events surrounding the unexpected death of a patient who was found outside the Sepulveda Nursing Home Care Unit. The complainant alleged negligence, lack of supervision, lapses in safety procedures, and problems with facilities and services as the causes for this suspicious death.

We did not substantiate the complainant's allegations of negligence, nor did we substantiate the allegation that the patient's death occurred under suspicious circumstances. We confirmed the absence of patient supervision, lapses in safety, and problems with the physical security of the facility. We found that employees did not periodically monitor the patient's whereabouts at prescribed intervals, as required. We identified deficiencies in the documentation of patient incidents and found instances of inconsistent application of the facility's search procedure. We identified several lapses in safety procedures, including a breakdown in immediately notifying the charge nurse of the incident, failure to notify applicable employees when the patient left the unit, and inadequate security of the tunnel door and construction site. We found vulnerabilities pertaining to inadequate monitoring of the surveillance cameras and the absence of emergency telephone equipment in the tunnels.

We made six recommendations to improve the education and training of employees on assessment, prevention, and management of missing patient events and search procedures. The Acting Director agreed with the findings and recommendations, and provided acceptable implementation plans. (*Healthcare Inspection - Missing Patient Issue, VA Greater Los Angeles Healthcare System, Los Angeles, CA, 02-00821-120, 6/14/02)*

Issue: Medical treatment and patient abuse.
Conclusion: Physician's performance and conduct warranted additional monitoring and review.
Impact: Strengthened policies and education related to pain management and informed consent will improve services.

A complainant, who was an employee, alleged that a physician provided questionable medical treatment and abused a patient by failing to manage the patient's pain during a clinic procedure, and by speaking to the patient in an inappropriate manner. The complainant provided a letter that the patient gave to him regarding the treatment he received. In his letter the patient stated that the treating physician used a pair of scissors and a needle to treat his infected foot wound, resulting in severe pain. The patient wrote that the physician was unwilling to administer local anesthesia despite the patient's physical and verbal expressions of pain. The patient also wrote that the physician made demeaning statements to him during the procedure. The complainant stated that another employee witnessed a portion of the patient's procedure. The complainant also alleged other employees would not report their observations of misconduct or suspected patient abuse, because they feared reprisal and claimed that managers were unresponsive to complaints submitted to the patient representative.

We did not substantiate the allegations that the physician provided questionable medical treatment and abused the patient, or that managers failed to respond to reports of this physician's alleged misconduct. We reached this conclusion taking into consideration the patient's adamant statement

to us that he was not abused. Nevertheless, we concluded that the physician should have assessed and managed the patient's pain more adequately and spoken to the patient in a more respectful manner. The physician's performance and conduct warranted additional monitoring and review. We also identified deficiencies in the documentation of informed consent and the assessment of pain. We found that the patient abuse, pain management, and informed consent policies needed revision to clarify criteria and responsibilities. Employees also needed additional education and training related to the pain management and informed consent policies.

We made three recommendations to address the issues. The Director agreed with the findings and recommendations and provided acceptable implementation plans. *(Healthcare Inspection - Patient Treatment Issues, Northern Arizona VA Health Care System, Prescott, AZ, 02-00130-119, 6/17/02)*

Issue: Reporting to the National Practitioner Data Base (NPDB).
Conclusion: One physician's actions should have been reported.
Impact: Make all facility managers aware of reporting requirements, and ensure other institutions have access to information on questionable physicians.

The medical center Director allegedly did not comply with VHA requirements when he did not report two physicians to the NPDB, after their privileges were revoked or reduced for more than 30 days. The complainant also alleged that a third physician left under circumstances that may have involved similar violations. The Director also allegedly entered into a settlement agreement with one of the physicians to accept a resignation in exchange for not reporting an adverse action to the NPDB.

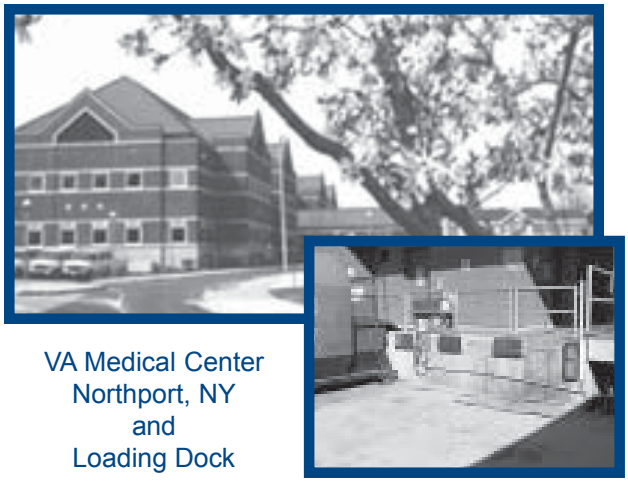
We substantiated the allegation that one of the two physicians should have been reported to the NPDB based on unsatisfactory ratings in clinical competence and other factors. The medical center Director did not comply with VA requirements that prohibit officials from entering into settlement agreements as a means to remove employees in lieu of reporting serious infractions to the NPDB. The second physician did not meet criteria for reporting to the NPDB, because his clinical privileges were unrestricted. The third physician was reported to the NPDB.

We made three recommendations that should prevent further similar occurrences and make all facility managers aware of the requirements of reporting to the NPDB. The VISN Director agreed with the findings and recommendations and provided acceptable implementation plans. *(Healthcare Inspection - National Practitioner Data Bank Reporting Issues, VAMC Dayton, OH, 01-00886-124, 6/25/02)*

Issue: Supervision of a nursing home care unit (NHCU) patient.
Conclusion: Employees did not adequately supervise the patient.
Impact: Strengthened procedures for monitoring patients at risk for wandering will reduce the risk of injury or death.

An anonymous complainant alleged that employees did not adequately supervise a NHCU patient. The patient allegedly left his nursing unit in a wheelchair without the knowledge of NHCU employees and subsequently fell 6 feet off a loading dock. He was severely injured and later died from the injuries. As shown below, a railing was later added to the dock to preclude other patients from being injured.

We substantiated the allegation that employees did not adequately supervise the patient. We found that: (i) NHCU clinicians had not followed several



VA Medical Center
Northport, NY
and
Loading Dock

procedures for monitoring the patient who was at risk of wandering from the unit; (ii) the patient's monitoring transmitter had not functioned properly; (iii) the patient had access to a nearby loading dock that had not been adequately secured; (iv) police did not respond promptly; and (v) employees first on the scene did not secure evidence at the accident site to permit an adequate investigation.

We made seven recommendations that should reduce the chance of similar incidents occurring. The medical center Director agreed with the findings and recommendations and provided acceptable implementation plans. *(Healthcare Inspection - Patient Care and Management Issues, VAMC Northport, NY, 01-00127-128, 7/01/02)*

Issue: Quality of care.
Conclusion: Patient received a duplicate medication order.
Impact: Improved procedures to prevent medication errors.

We received complaints from a patient's daughter regarding the quality of care her father received at VAMC West Palm Beach. Specifically, she alleged that: (i) her father's health deteriorated because of a medication error; (ii) he was prematurely discharged after a surgical procedure; (iii) the feeding tube placement led to an infection that resulted in his death; (iv) blood cultures were not drawn in a timely manner; and (v) he was not fed for 30 days. She also alleged that a social worker was rude to her.

We substantiated that a medication error occurred. We found that a pharmacy computer alert (order check) warning was disabled. Therefore, the pharmacist who processed the second order for medication had not received a computer alert warning him that the physician had ordered the same medication twice. Managers immediately corrected the problem, and also verified that the check order feature was enabled for all providers. While the increased dosage of medication may have caused the patient to become mildly dehydrated, he was immediately and appropriately treated. We did not substantiate allegations (ii) through (v). We could not substantiate or refute the allegation that a social worker was discourteous to the complainant. There were no witnesses to the alleged event and the complainant had not filed a complaint with the patient advocate. Further, the patient advocate and the social worker's supervisor told us that there had never been any complaints against this provider in the past. Because facility managers had already taken appropriate corrective actions regarding the medication error, we did not make any recommendations. *(Healthcare Inspection - Patient Treatment and Employee Behavior Issues, VAMC West Palm Beach, FL, 02-00279-138, 7/16/02)*

Issue: Patient transfers.
Conclusion: It would have been prudent to transfer one of the patients to the nearest community hospital.
Impact: Strengthened transfer policies and reduced risk of further complications from not treating patients promptly.

A complainant alleged that VISN 12 did not provide adequate backup and referral support for two patients who were in need of urgent surgical care. The two patients initially presented to

clinicians at VAMC Tomah, WI, and VAMC Iron Mountain, MI, respectively, and both were transferred more than 200 miles away to the Edward Hines Jr. VA Hospital in Hines, IL.

We concluded it would have been prudent to transfer the first patient to the nearest community hospital having substantial surgical expertise. Two such hospitals could have been used and were less than 50 miles away. In the second patient's case, we did not substantiate the allegation that appropriate surgical care was delayed due to lack of available beds at referral tertiary VAMCs. We concluded, in the second case, that clinicians took aggressive and appropriate steps to locally stabilize the patient before transfer to the VA Hospital in Hines.

The VISN Director did not concur with our conclusions and did not adequately respond to our two recommendations. We elevated the recommendations to the Deputy Under Secretary for Health for Operations and Management for resolution. The Deputy Under Secretary concurred with our recommendations and provided acceptable implementation plans. *(Healthcare Inspection - Alleged Inappropriate Transfers of Patients in VISN 12, 01-01512-139, 7/18/02)*

Issue: Discharge planning.
Conclusion: VAMC staff provided inaccurate information to the Home Health Agency (HHA).
Impact: Strengthened facility policy to ensure clinicians record all applicable information.

A complainant alleged that a patient was released without appropriate discharge planning from VAMC Cheyenne. The complainant also alleged that the VA nursing referral form sent to the HHA was incomplete and inaccurate, and that the patient was discharged without any wound care supplies to take home.

We did not substantiate the allegation that clinicians discharged the patient prematurely. The patient was competent and elected to leave the hospital and return home contrary to his physician's advice that he needed long-term care. We substantiated the allegation that VAMC employees provided inaccurate and incomplete information to the HHA. The Director acknowledged that the allegation was true and had already strengthened facility policy to better ensure that clinicians record all applicable information in the future. VAMC employees also provided assistive equipment, made structural changes to the patient's home, and increased the frequency of HHA services for the patient. We also substantiated the allegation that the patient did not receive wound care supplies when he was discharged. The Director acknowledged that the allegation was correct and that employees had failed to adhere to local policy and order the supplies sufficiently in advance to ensure the patient would have the supplies when he left the medical center.

We made two recommendations to address the substantiated issues. The Director agreed with our findings and recommendations and provided acceptable implementation plans. (*Healthcare Inspection - Discharge Planning Issues, Veterans Affairs Medical Center Cheyenne, WY, 01-02684-137, 7/18/02)*

Issue: Residential care home placement, and timeliness and quality of health care.
Conclusion: Community residential care homes that did not meet standards, VA personnel did not supervise the properties, and a clinician did not provide timely patient care.
Impact: Improved health care for veterans.

We received several allegations from anonymous complainants concerning patient safety, quality of care, administrative management issues, and medical record documentation. The complainants alleged that: (i) clinical managers placed patients in community residential care homes that did not

meet fire and safety standards, and VA personnel did not supervise or inspect the properties; (ii) the medical-officer-of-the-day did not provide timely care to a patient because his shift was ending; (iii) clinicians did not adequately monitor patient falls and injuries; (iv) managers instructed patient representatives not to record all complaints in the patient advocate tracking system; (v) quality managers were told not to notify the VISN when patients were reported missing from the facility; (vi) the Director does not have an "open door" policy that provides employees opportunities to voice their concerns; and (vii) clinicians erroneously documented treatment in a patient's medical record.

We substantiated allegations (i) and (ii) above. We also found that community resource managers did not consistently provide sponsors with adequate information about the patients' needs and required levels of supervision. We did not substantiate allegations (iii) through (vii). However, we did confirm that nursing employees on one ward were unaware that a patient was absent from the medical ward.

We made three recommendations to improve care for veterans. The Director agreed with our findings and recommendations and provided acceptable implementation plans. *(Healthcare Inspection - Patient Care and Management Issues at the Central Alabama Veterans Health Care System Tuskegee, AL, 01-01090-147, 8/05/02)*

Issue: Adequacy and safety of work environment.
Conclusion: Indoor air quality and mold contamination tests failed to identify health risks.
Impact: Improved cleanliness, air quality, and assurances that employees are safe.

We reviewed an allegation concerning the adequacy and safety of the work environment in the telephone office. Complainants alleged that exposure to unknown substances in the telephone operations area resulted in serious health problems for employees. We were unable to substantiate or refute the allegation of an unhealthful work environment. There was no direct evidence linking the employees' health symptoms with the work environment. Indoor air quality and mold contamination tests failed to identify any cause of the employees' complaints. Managers took actions to thoroughly clean the work areas. Managers also plan to install a new ventilation system that will serve the affected area. In addition, managers requested assistance from the Occupational Safety and Health Administration to help resolve the issue.

We made two recommendations. The VISN Director concurred and agreed that the facility would continue cleaning and air quality testing in the telephone operations area until the ventilation system replacement is completed. The VISN Director also agreed to send a copy of the Occupational Safety and Health Administration study and resulting actions to the OIG. *(Healthcare Inspection - Work Environment Issue, Southern Arizona VA Health Care System, Tucson, AZ, 02-02160-160, 9/04/02)*

Issue: Prescribing controlled substances.
Conclusion: Prescribing pattern permitted a patient to accumulate large quantities of controlled substances.
Impact: Reduce risk of prescription drug overdoses.

We reviewed allegations publicized by a Florida newspaper article questioning the issuance of prescriptions for narcotics, sedatives, and other controlled substances at the West Palm Beach and Miami VA medical centers. The article questioned the appropriateness of VA clinicians' prescription practices and whether the medications dispensed contributed to the deaths of 11 patients. We confirmed that all 11 veterans died in their communities from drug overdoses, as documented by medical examiner reports. However, we did not substantiate the allegation that VA clinicians inappropriately prescribed controlled substances to

10 of the 11 patients. Upon toxicological analysis, only 2 of the 11 patients had controlled substances in their blood streams that were solely and recently prescribed by VA clinicians. In 10 of the 11 cases, we found that controlled substances were prescribed appropriately. While perhaps no single prescription was inappropriate in the remaining case, the prescribing pattern permitted the patient, who was known to have a drug abuse problem, to accumulate large quantities of controlled substances. We did not attribute the death of any of the 11 patients to arbitrary or careless prescribing of controlled substances.

Three recommendations were made to strengthen provider procedures and pharmacy controls to avoid recurrence. The VISN Director, in conjunction with the Directors at the two VA medical centers, concurred with the findings and provided acceptable implementation plans. *(Healthcare Inspection - Review of Prescription Practices at VAMCs West Palm Beach and Miami, FL, 02-02108-162, 9/09/02)*

Issue: VA-contracted community nursing home.
Conclusion: VA clinicians did not provide monthly follow up visits.
Impact: Improved communications and assurances that patients are adequately cared for and are safe.

We received allegations of inadequate social services and inappropriate veteran funds management at the VA Puget Sound Health Care System. A complainant alleged that the staff did not provide regular social services to monitor and coordinate care provided to a veteran by a contract nursing home. The complainant also alleged that the contract nursing home fraudulently charged the veteran's estate for medical services.

We substantiated the allegation that the VA facility's clinical employees did not provide monthly follow up visits, coordinate the complaint received from the family, or resolve the complainant's concern regarding the veteran's funds. Better communication between VA clinicians and the VBA examiner would have addressed these complaints.

We did not substantiate the allegation that the VA-contracted community nursing home fraudulently charged the veteran's estate for medical services. The complainant believed that the billing for private care was unwarranted as the home was under contract with VA. Although non-VA care was obtained, we attributed the confusion to poor communications between the home and VA administrators, and with the complainant.

The VISN Director concurred with the five recommendations we made to improve communications and controls and he provided acceptable implementation plans. *(Healthcare Inspection - Management of Patient Funds, VA Puget Sound Health Care System, Seattle, WA, 02-01837-165, 9/11/02)*

VA Puget Sound Health Care System
Seattle, WA

Issue: Providing VA patients priority care in the cardiac catheterization laboratory.
Conclusion: Managers needed to develop policies and monitor quality of care.
Impact: Improved oversight of the quality of procedures provided to patients.

We reviewed an allegation that VA managers allowed the university affiliate to refer non-VA heart patients to be seen and treated at the

healthcare system ahead of acutely ill VA heart patients, thus according VA patients a lower priority for this care. We found that VA managers had a sharing agreement with the university that permitted non-VA patients to receive cardiac catheterizations after all VA patients were treated. Although we found that seven university patients were scheduled for care in the catheterization laboratory ahead of VA patients, we did not find any evidence that the seven incidents constituted a trend. Nor did we find that any of the seven VA patients required emergent surgical interventions, or that any of them were exposed to increased risks of dying because of the brief delays. We did not find evidence that VA patients received poor care. We found that VA catheterization laboratory managers had not developed written policies and procedures, nor had they developed a centralized data repository to track and trend patient information and outcomes. We had to review multiple sources (logbooks, event logs, and other reports) to obtain complete assessments of the care patients received.

We recommended managers develop and implement written policies and procedures, and establish a database to track and trend patient information and outcomes. We also recommended linking catheterization laboratory operations with the facility's quality assessment and improvement programs. The VISN Director and medical center Director agreed with the recommendations and provided acceptable implementation plans. *(Healthcare Inspection - Cardiac Catheterization Laboratory Issue, Central Arkansas Veterans Healthcare System, Little Rock, AR, 01-02036-167, 9/17/02)*

Issue: Quality of care at a state veterans home.
Conclusion: Documentation of incident report deficiencies existed.
Impact: Improved documentation, training, and customer service.

We received a request from Senator Christopher S. Bond to review a complainant's allegations that employees working for the Missouri Veterans Home special care unit provided poor care to a veteran during his stay. We were not able to substantiate or refute the complainant's allegations of poor care. However, we identified deficiencies in the documentation of incidents. We also identified a need for nursing home employees to be better trained on providing personal care for residents with dementia, especially during times of increased confusion and agitation. Additionally, we identified opportunities to improve follow up reviews of reported incidents and communication of the circumstances surrounding these reported incidents with residents and families.

We concluded that the VAMC St. Louis review team needed to monitor Missouri Veterans Home managers' actions to improve documentation of incident reports, provide employees additional training on caring for patients with dementia, and improve customer service. The acting VISN Director and medical center Director agreed with our recommendations and provided acceptable implementation plans. *(Quality Care Issues, Missouri Veterans Home, St. Louis, MO, 02-02369-168, 9/18/02)*

Healthcare Inspections (Oversight Inquiries)

During the reporting period, OHI oversaw the completion of 99 Hotline cases referred to VHA for action. These cases involved 136 allegations, of which 37 (27 percent) had merit based on the information available. VA managers acted to create new or strengthen existing procedures, take administrative actions, offer more education and training, improve the quality of services, strengthen patient safety procedures, enhance the physical plant environment, and realign resources.

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 Division - The Division is responsible for determining action to be taken on allegations received by the OIG Hotline. The Division receives thousands of contacts annually, mostly 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 Division - The Division does follow up tracking of OIG report recommendations; Freedom of Information Act releases; strategic, operational, and performance planning; and IG reporting and policy development.

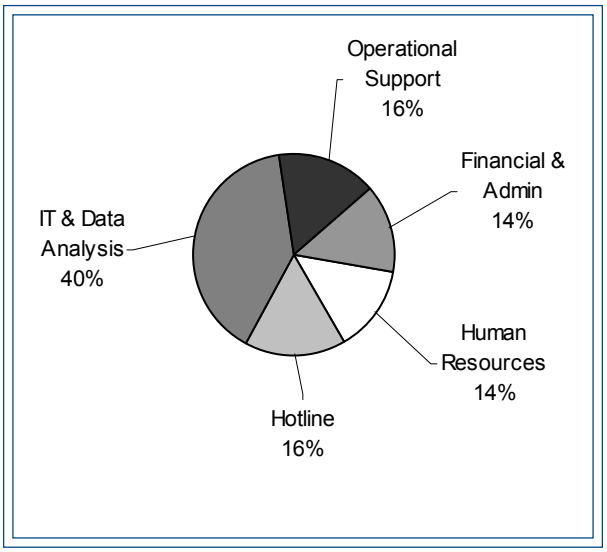
III. Information Technology (IT) and Data Analysis Division - The Division manages nationwide IT support, systems development and integration; represents the OIG on numerous intra- and inter-agency IT organizations; and does strategic IT planning for all OIG requirements. The Division maintains the Master 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 Division - The Division is responsible for OIG financial operations, including budget formulation and execution, and all other OIG administrative support services.

V. Human Resources Management Division - The Division is responsible for OIG personnel management, which includes classification, staffing, employee relations, training, and incentive awards programs.

Resources

The Office of Management and Administration has 55 FTE allocated to the following areas.



I. HOTLINE DIVISION

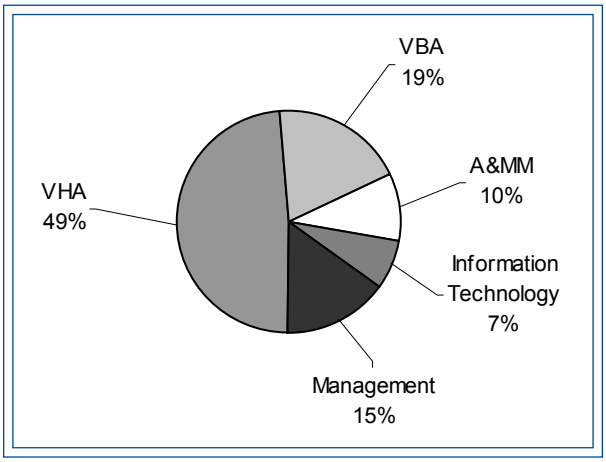
Mission Statement

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

Resources

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



Output

- During the reporting period, Hotline staff closed 746 cases, of which 221 contained substantiated allegations (30 percent). The Hotline staff generated 164 letters responding to inquiries received from members of the Senate and House of Representatives.

Outcome

- VA managers imposed 70 administrative sanctions against employees and took 90 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled over $60,000.

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

Veterans Health Administration

Quality of Patient Care

The responses to Hotline inquiries by VA management officials indicated that 38 allegations regarding deficiencies in the quality of patient care provided by individual facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VAMC review found poor coordination and communication between the facility fee-basis office and referring physicians. A veteran experienced a 2-month delay in a fee-basis referral for removal of a basal cell carcinoma growth from his back. Although this was not life threatening, the veteran experienced undue stress during this delay, and the fee-basis office failed to keep the referring physician informed of the status of her consult. The facility contracted with several dermatologists in the area for expeditious service and established a referral process with another VAMC for more emergent cases. Further, a process for tracking the status and outcome of fee-basis referrals was implemented by the business office. Management apologized to the veteran for the delay.

- A VISN review substantiated a 1-year delay in a veteran's neurological evaluation as a result of a lack of communication and coordination of care between two VAMCs. Additionally, the veteran was billed for fee-basis services by the vendor. The veteran has since received the neurological evaluation and is currently under appropriate medical care. Management reimbursed the veteran for the incorrect charges and is working on better coordination of care between the two facilities.

- A VHA review found that a veteran, who was new to the facility, was not advised to provide his medical treatment records. This resulted in a delay of his care. The review found the veteran was treated with a lack of courtesy by both clerical and nursing staff, and a cardiologist consultant failed to provide a follow up response to the veteran's referring primary care provider. Management counseled all staff involved, and an apology was issued to the veteran.

- A VHA review found there was insufficient coverage for a therapy group on one occasion when the group's psychiatrist was on military leave. The review also found that the patients' food was served at improper temperatures over a period of several days, and that the patients' drinking mugs were not properly cleaned. Management implemented processes to ensure coverage of the group therapy sessions, changed procedures to ensure food is properly warmed, and the facility is now using disposable mugs.

- A VHA review substantiated the allegation that a veteran's primary care physician failed to report his test results to him in a timely manner. The medical resident who ordered the test was absent at the time the results were received. Therefore, the computerized medical records system view alert went unnoticed. Management upgraded the medical records system to alert the attending physician and the primary care physician of returned test results.

- A VHA review determined that during a conversation on the quality of care provided to his father, a physician and the patient's son engaged in a confrontational conversation that progressed to the point where both individuals used profanity. Management counseled the physician who promised that this behavior would not happen again.

- A VAMC review substantiated that a veteran was mistakenly referred to the mental health clinic instead of the ear, nose, and throat clinic for treatment of Meniere's Syndrome. Management is making every effort to assure that the veteran receives appropriate care for his condition. The clinic has evaluated the veteran and will be managing his care.

- A VAMC review substantiated that staff in the eye clinic failed to follow established medical center procedure in a medical emergency. This failure caused a delay in the treatment of a veteran. The veteran was taken to the emergency room for care and later admitted for observation. Management has provided training for all staff concerning proper procedures to be followed in a medical emergency situation.

Employee Misconduct

The responses to Hotline inquiries by management officials indicated that 12 allegations of employee misconduct at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VHA review found that a supervisor improperly sold clothing and jewelry to subordinates during duty hours. The employee received an admonishment.

- A VAMC board of investigation found that a certified registered nurse anesthetist behaved in a threatening manner towards the interim chief of anesthesia. The board recommended taking

personnel action against the nurse for his threatening behavior, expanding the surgical service orientation-training program, and expediting the recruitment of a permanent chief.

- A VHA review found that a VA police officer, who acted as an agent for pre-paid legal services, tried to sell the services to his fellow officers during his official duty hours. The chief of police is taking administrative action against the employee.

Time and Attendance

The responses to Hotline inquiries by management officials indicate that four allegations of time and attendance abuse at individual VA facilities were found to have merit and required corrective action. An example follows:

- A VHA review found a full-time psychologist was teaching at an outside facility during his tour of duty. Management issued letters of admonishment to the psychologist and the psychologist's supervisor.

Fiscal Controls

The responses to Hotline inquiries by management officials indicate that seven allegations of deficient or improper fiscal controls at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VAMC review substantiated a clerical error in the reimbursement of a veteran's cost for authorized special handicapped adaptation of his vehicle. The facility transposed figures in completing the paperwork for reimbursement, authorizing a check for $1,428 instead of the correct amount of $4,128. The facility contacted the veteran to apologize and issued a check for the difference.

- A VHA review found that a veteran and his wife, who is also a veteran, submitted payment along with two statements to be applied to both his and her accounts. However, the payment was only applied to one account causing administrative charges and interest to accrue on the unpaid account. Management recommended the veterans submit separate payments or mail the payments directly to the facility and not to a lockbox address. A waiver was applied to the administrative charges and interest on the unpaid account.

- A VHA review determined that an employee received a relocation bonus for a transfer from one VAMC to another nearby VAMC, but did not establish a residence in the new VAMC's commuting area. However, the employee maintained her home and commuted daily to the new VAMC. Due to confusing guidance on this issue in VA regulations and their failure to make reference to 5 CFR 575.205, paragraph C, the human resources and technical advisors were unaware of the CFR requirement that clearly states the employee must establish a residence before a relocation bonus can be paid. Management initiated a bill of collection for $5,000 and advised the employee of her due process right to request a waiver. Human resources and fiscal staff have been instructed to validate proof of appropriate residence before paying relocation bonuses, and management is auditing past relocation bonuses to determine if similar overpayments have occurred. They will take appropriate collection action when necessary.

- A VHA review of delays in the processing of checks resulted in the reassignment of the full-time cashier to other duties in the VAMC's fiscal service. Management also implemented a log system to account for the checks and the timeliness of processing. Other new controls included additional instructions on where to store checks and improved transmittal systems.

Patient Safety

The responses to Hotline inquiries by management officials indicate that five allegations of patient safety deficiencies at individual VA facilities were found to have 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 the process of disciplining the social worker and the psychologist.

- A VHA review found that an 82-year-old veteran, diagnosed with dementia, was not properly supervised while attending an appointment at the VAMC and wandered off for a period of approximately 5 hours. The veteran was found by the local police department and was eventually returned home. Management has implemented numerous corrective measures to ensure geriatric veterans are closely monitored within the VAMC.

- A VHA review found that a pharmacy failed to complete a non-formulary request for a veteran's oral diabetes medication, which resulted in the medication not being dispensed to the veteran. Management is revising the policy of dispensing medication, and a copy of the policy will be distributed to the members of the medical and pharmacy staff.

- A VAMC review substantiated a delay in treatment of an inpatient, poor communication, and poor documentation. The mother of an inpatient requested suctioning of her son prior to his eating. Nursing staff contacted respiratory therapy staff for assistance, but a therapist was not immediately available. Although nursing claims they continually contacted respiratory therapy, there was no documentation of this in the patient's medical records. Almost 2 hours later, respiratory therapy was contacted and a therapist arrived within 5 minutes to treat the patient. Management counseled the staffs on timely follow up, and communication of patient issues and concerns.

Government Equipment and Supplies

The responses to Hotline inquiries by management officials indicate that three allegations involving misuse of Government equipment and supplies at individual VA facilities were found to have merit and required corrective action. The summaries follow:

- A VHA review substantiated the allegation that surgical supplies were missing from the VAMC's operating room. A team leader found the missing items and returned them to the operating room.

- A VHA review found that a physician failed to secure her blank prescription pads, which allowed an unknown individual to take at least four blank prescriptions from her lab coat. The physician has agreed to secure her pads in a locked location.

- A VHA review determined a supervisor used his Government credit card to make purchases that were inconsistent with established guidelines and acquisition procedures. The supervisor received refresher training in the appropriate use of a Government credit card. Action was taken to ensure that the items purchased are added to the facility's equipment inventory.

Contracting Activity

The responses to Hotline inquiries by management officials indicate that five allegations involving contracting improprieties or problems with contracted 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 a veteran received only a partially-filled oxygen tank. Management discussed the incident with the contractor and was informed that drivers were advised to check the patients' air supply before leaving the patients' homes.

- A VHA review found that a VA contracted home health care provider failed to provide adequate care to a patient. The VAMC obtained an alternate home health care provider to provide service to the patient. Management is closely monitoring future services of the original provider and will take appropriate corrective action, if warranted.

- A VHA review found that a veteran experienced difficulty in obtaining consistent in-home care from a VA contracted home health care provider. Due to the highly regimented care and time demands placed on the providers (six different contractors in the past 6 years) by the veteran and his mother, consistent care was disrupted on seven occasions. The VAMC and contractor are continuing to work with the veteran and his mother to provide consistent care.

Personnel Practices

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

- A VAMC review determined that a service chief violated VAMC policy on approval and documentation of overtime, compensatory time, and flexi-place for at least one of the employees. Management counseled the service chief and is taking steps to ensure his future compliance.

- A VHA review found a nurse supervisor made racially-insensitive remarks to her subordinates during a meeting. The supervisor received a letter of counseling. She issued a formal apology to her staff. Additionally, she is scheduled to receive training on diversity and sensitivity.

- A VAMC review substantiated that an employee had her child performing routine office activities in her work area as an unauthorized volunteer. Management counseled the employee and instructed her not to bring her child to work in the future.

Ethical Improprieties

The responses to Hotline inquiries by management officials indicate that five allegations involving violations of ethical conduct standards at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VAMC board of investigation found that a supervisor who worked for both the medical center and the associated research corporation had an inherent conflict of interest as decisions made for the research corporation affected his VA staff. Furthermore, because he directed his staff to perform duties in support of his work with the research corporation, he was perceived by co-workers to have abused his authority. The board recommended that VA employees hired by the research corporation certify that all work being performed is outside of their VA duty hours.

- A VAMC review substantiated that an employee used his Government telephone to make calls on behalf of a local political organization. The employee was verbally counseled and agreed to cease such activities. This matter was referred to the Office of Special Counsel.

Abuse of Authority

The responses to Hotline inquiries by management officials indicate that five allegations involving abuse of authority by employees at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VHA review substantiated that a VAMC chief of police misused his Government time and his VA cell phone, and manipulated the time and attendance system. The review established that the cell phone misuse resulted in a waste of 32 duty hours, that the time and attendance system manipulation gave the chief 1.5 days of unauthorized administrative leave, and that the chief was receiving a uniform allowance even though he only sporadically wore his uniform. The management review also established that the chief misused his official position when he directed his staff to conduct a personal surveillance of his former girlfriend. The chief chose to retire and reimburse the Government $948 for the wasted Government duty time when management proposed terminating his employment.

- A VHA review found that outpatient clinic employees were at times using inappropriate and offensive language in their dealings with each other and with patients. Management counseled two administrative and two clinical employees.

Facilities and Services

The responses to Hotline inquiries by VA management officials indicated that 29 allegations regarding deficiencies with facilities or the services provided by individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VAMC review determined that a VA employee and a veteran became involved in a verbal altercation when the veteran entered a restricted area. The employee's supervisor counseled the employee about her behavior and suggested strategies for diffusing such episodes in the future. In addition, the review found a miscommunication between two specialty clinics about patient medication led to the argument. Management verbally counseled clinic employees and amended procedures to enhance communications on patients managed by more than one clinic.

- A VAMC review found that its new emergency room facility did not have an area in which patients could privately discuss their concerns. Management is modifying the configuration to address this problem and is continuing to monitor operations to protect the privacy of the patients.

- A VHA review found that patients were having problems in refilling their prescriptions through the VAMC's automated telephone system. As a result, the pharmacy service is currently developing a plan to correct identified issues related to the telephone system and ensure that patients are able to easily access the service.

- A VAMC review found a veteran's primary care physician failed to properly process a referral for fee-basis treatment, thus causing confusion when the veteran appeared at a private pain clinic for a surgical procedure. A previous referral was updated and used to permit the procedure to be conducted as scheduled, and the physician was reminded of the proper handling of referrals. Additionally, the veteran complained that despite standing orders in the pharmacy to mail his prescriptions, a prescription for pain medication was marked for pick-up. Following an inquiry by Hotline, the medical center faxed a prescription for an emergency supply to a local pharmacy and sent the 30-day supply by overnight delivery.

- A VAMC review found that lapses in administrative services by ear, nose, and throat clerical staff resulted in patients not being properly notified of cancelled or rescheduled appointments. Further, the review determined that, although the complainant had been trying for a year to get a faulty glucometer repaired or replaced, prosthetics was unaware of the problem. Management reviewed facility procedures on appointment notification with staff and reminded them of the importance of maintaining good customer service. Prosthetics contacted the complainant to arrange for a replacement glucometer.

Veterans Benefits Administration

Receipt of VA Benefits

The responses to Hotline inquiries by management officials indicate that 17 allegations involving improprieties in the receipt of VA benefits were found to have merit and required corrective action. Examples of the issues follow:

- A VBA review found that a veteran had misused his educational benefits. The veteran's educational award was retroactively cancelled, creating a $26,672 overpayment.

- A VARO review found that a veteran was working full-time while he collected a zero-income-based pension. In addition, the review found the veteran failed to file an annual eligibility verification report. Management terminated the veteran's benefits, creating an overpayment of $7,813.

- A VBA review found that a pensioner failed to report income derived from SSA and his job. The VARO terminated the veteran's pension, creating an overpayment of $8,075.

- A VBA investigation resulted in the reduction of a veteran's compensation from 90 percent to 10 percent due to his conviction and incarceration. The amount recovered is $11,323.

Facilities and Services

The responses to Hotline inquiries by management officials indicate that six allegations involving facilities and services at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VBA review found that the processing of a veteran's claim was delayed, because his physical examinations were released to a VARO before they were deemed adequate and complete for rating purposes. Management hired new personnel to complete compensation and pension examinations, review the adequacy of the completed physical examinations, and assist with the processing of claims.

- A VBA review found that a debt waiver request submitted by a veteran to a VARO was not forwarded in a timely manner to the Debt Management Center. The veteran contacted the Center on the day the waiver was faxed and was given erroneous information by several employees who were unaware that an indebtedness recall was in process. The review also found that Debt Management Center employees treated the veteran with discourtesy. Management counseled the employees.

- A VARO review of a veteran's file substantiated that his appeal was closed prematurely when he was accidentally listed as deceased. The VARO reactivated his appeal.

- A VARO review found the office staff mishandled a veteran's claim file on several occasions. The review found the VARO failed to schedule the veteran for a hearing, failed to answer the veteran's e-mail inquiries, and failed to locate the veteran's claim file in a timely manner. Management has implemented numerous controls and procedures to correct processing deficiencies.

Employee Misconduct

The responses to Hotline inquiries by management officials indicate that six allegations involving employee misconduct at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VBA review found that a temporary employee was improperly collecting transit benefits while driving to work on a daily basis. Management terminated the employee and is recovering the $420 in transit subsidies.

- A VBA review found an employee left his duty station 15 to 20 minutes early on a daily basis to reduce his commuting time. Management counseled the employee and informed him that he is expected to work his tour of duty.

- A VBA review determined that a vocational rehabilitation counselor was improperly using a Government vehicle for home-to-work commuting, including taking the vehicle home unnecessarily on Friday evenings prior to Federal holidays. As a result, management established a new field trip log to reflect only the actual visits to facilities and veterans and a quarterly review of vehicle credit card use in conjunction with the new log. Additionally, management changed the approval process for taking a Government vehicle home at night to ensure compliance with a regional office circular. However, based on this report, OIG determined that VA policy is not in compliance with the statutory requirement that only the head of the agency can approve home-to-work commuting in Government vehicles and referred the issue to the Office of General Counsel.

- A VARO review found a VA employee used her Government computer to forward a chain e-mail to a list of other VA employees. Management proposed a 5-day suspension.

National Cemetery Administration

Personnel Practices

A review determined that while no evidence of wrongdoing was discovered, in this specific instance, a lack of effective supervisory oversight may have contributed to the resignation of two employees from their positions. The review team recommended that first-line supervisors address office rumors and other employee misconduct consistently, and that management monitor first-line supervisor responsibilities relating to personal conduct.

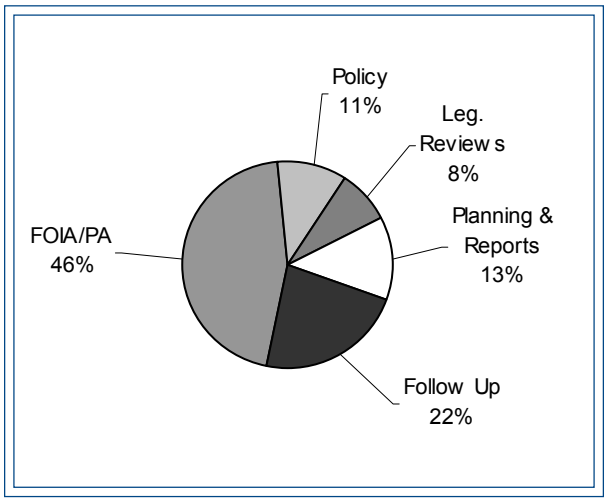
II. OPERATIONAL SUPPORT DIVISION

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

The Division is responsible for obtaining implementation actions on previously issued audits, inspections, and reviews with over $4 billion of actual or potential monetary benefits as of September 30, 2002.

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 as promptly as possible and that corrective actions are implemented as agreed upon by VA management officials. VA's Deputy Secretary, as the Department's audit resolution official, resolves any disagreements about recommendations.

After obtaining information that showed management officials had fully implemented corrective actions, the Division took action during this period to close 87 reports and 592 recommendations with a monetary benefit of $379 million. As of September 30, 2002, VA had 68 open OIG reports with 250 unimplemented recommendations.

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

The Division processes all OIG FOIA and PA requests from Congress (on behalf of constituents), veterans, veterans service organizations, VA employees, news media, law firms, contractors, complainants, general public, and subjects/ witnesses of inquiries and investigations. In addition, the Division processes official requests for information and documents from other Federal Departments and agencies, such as the Office of Special Counsel, the Department of Justice, and the FBI. These requests require the review and possible redacting of OIG hotline, healthcare inspection, criminal and administrative investigation, contract audit, and internal audit reports and files. We also process 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 272 requests under the FOIA and PA and released 282 audit, investigative, and other OIG reports. Information was totally denied in 3 requests and partially withheld in 165 requests because release would have constituted an unwarranted invasion of personal privacy, interfered with enforcement proceedings, disclosed the identity of confidential sources, disclosed internal Department matters, or was specifically exempted from disclosure by statute. During this period, 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

The Division coordinated concurrences on legislative and regulatory proposals from the Congress, OMB, and the Department that relate to VA programs and operations. The OIG commented and made recommendations concerning the impact of the legislation and regulations on economy and efficiency in the administration of programs and operations or the prevention and detection of fraud and abuse. During this period, we reviewed 73 legislative, 66 regulatory, and 59 administrative proposals.

Status of OIG Reports Unimplemented for Over 3 Years

We require management officials to provide us with documentation showing the completion of corrective actions on OIG reports, including reporting of collection actions until the amounts due VA are either collected or written off. In turn, we conduct desk reviews of 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, the follow up staff closes the recommendation after coordination with the OIG office that wrote the

report. If the actions do not implement the recommendation, we request a status update.

The following chart lists the total number of unimplemented OIG reports and recommendations. It also provides the total number of unimplemented reports and recommendations issued in FY 1999 and earlier.

VA Office	Unimplemented OIG Reports and Recommendations			
	Total		FY 1999 and Earlier	
	Repts	Recoms	Repts	Recoms
VHA	41	171	4	11
VBA	8	39	0	0
MGT	16	24	0	0
I &T	1	8	0	0
P&P	1	7	0	0
HRA	1	1	0	0
Total	**68**	**250**	**4**	**11**

Office of Management (MGT)
Office of Information and Technology (I&T)
Office of Policy and Planning (P&P)
Office of Human Resources and Administration (HRA)

We are particularly concerned about the FY 1999 and earlier reports that have not been implemented 3 years after being issued. The status and OIG concerns on these FY 1999 and earlier reports are summarized as follows.

Veterans Health Administration

Unimplemented Recommendations and Status (FY 1999 and Earlier Reports)

Report: *Evaluation of VHA's Policies and Practices for Managing Violent and Potentially Violent Psychiatric Patients, 6HI-A28-038, 3/28/96*
Recommendation: VHA managers should explore network flagging systems that would ensure employees at all VAMCs are alerted when patients with histories of violence present for treatment to their medical centers.
Status: The Chief Information Officer has begun the necessary work to implement an automated system wide tracking system for patient advisory flags. Planning work on this automated system began in August 2002 and is scheduled for completion by July 30, 2003. VHA will also develop training guidance on the appropriate use of patient flags.
Concern: The OIG is concerned because the latest VHA status shows that after 6 years the flagging system still has not been developed and the recommendation remains unimplemented. The OIG report included recommendations that were meant to strengthen areas that may reduce the incidence of injury associated with violence in inpatient psychiatric units.

Report: *Internal Controls Over the Fee-Basis Program, 7R3-A05-099, 6/20/97*
Recommendations: VHA should improve the cost effectiveness of home health services by: (1) establishing guidelines for contracting for such services, and (2) providing contracting officers with benchmark rates for determining the reasonableness of charges.
Status: VHA provided a draft directive to the OIG in January 2001. However, there was lack of consensus from field reviewers and non-concurrence from the OIG on the draft. VHA withdrew the directive from concurrence in August

2001 to begin a complete revision. The VHA geriatrics and extended care staff is formulating a policy, and a directive may be drafted in November 2002.

Concern: The OIG is concerned because no VHA plan has been provided to implement the recommendation. The June 1997 final report showed that contracting for home health services could save at least $1.8 million annually; however, the recommendations remain unimplemented.

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

Recommendations:

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) requiring staff to review and appropriately bill HEC referrals within 60 days of receipt, (b) notifying staff that means testing activities and billing and collection actions on HEC referrals will be actively monitored by VISN and facility management, (c) 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 (d) 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: Current start up for the IVM process is scheduled for the first quarter, FY 2003 with additional software enhancements currently scheduled for the third quarter, FY 2003. VHA will publish a directive when the program is reactivated and it will include specific performance requirements for the billing activity. A request has been submitted for software enhancements that would automatically generate a bill within 60 days of referral. Once this software is in place, a monitoring process can be developed to evaluate the efficacy of that software as it relates to that billing standard. Referrals of IVM billing cases to VAMCs and the monitoring reports to reflect the results of the IVM activity will not occur until software enhancements are completed on the redesigned HEC information system. Procedures are being implemented to begin multiple year income verification upon the re-start of the verification program. The VHA Business Office will monitor the project and HEC's performance. Anticipate for multiple year income verification to begin during the second quarter, FY 2003. Based on the complexity of the new HEC database, the first billing referrals are anticipated during the third quarter, FY 2003. The new VHA Chief Business Officer has ordered a full review of the VHA means testing process. Significant changes are anticipated that may make the centralization of means testing unnecessary.

Concern: The 1999 audit found the recommendations made in a March 1996 OIG report on VHA's income verification match program were not fully implemented. We are concerned because the 1999 report showed that VHA could increase funding available for health care by $14 million and put resources valued at $4 million to better use; however, the recommendations remain unimplemented.

Report: *Administrative Investigation, Contracting Issues at the VA Chicago Health Care System, Chicago, IL, 9PR-E03-143, 9/15/99*

Recommendation: Issue a bill of collection to a retired VA employee to recoup the amount of her voluntary separation incentive (Buyout).

Status: The offset from the individual's retired pay should start in November 2002 via the Department of Treasury offset program.

Concern: The VA Chicago Health Care System awarded a personal services contract to a retired

VA employee who had previously received a voluntary separation incentive payment. The statutory provision that authorized the buyout requires repayment when an employee enters into a Government personal services contract. The OIG is concerned that the final report was issued in September 1999; however, VHA/VISN 12 did not issue a bill of collection for $25,000 until January 2001 and delayed the hearing on the waiver request until January 2002. In addition, the VISN did not submit the offset request to the Department of Treasury until August 2002.

III. INFORMATION TECHNOLOGY AND DATA ANALYSIS DIVISION

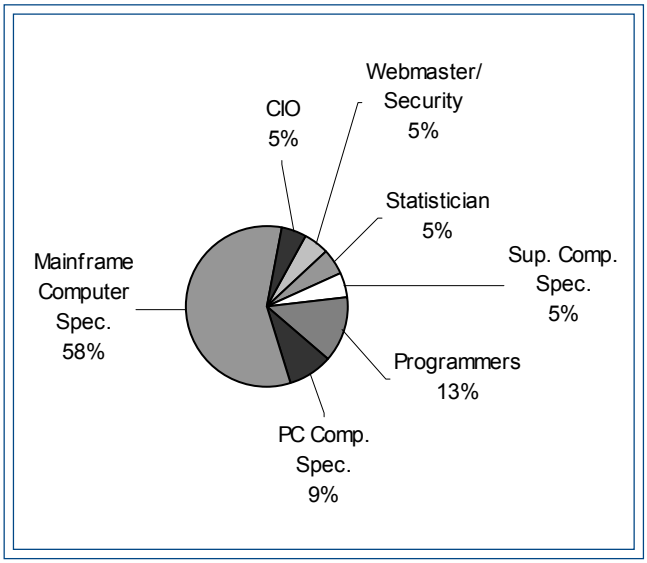
Mission Statement

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 Division, which is managed by the OIG's Chief Information Officer, represents the OIG on numerous intra- and inter-agency IT organizations and is responsible for strategic 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 this division serves as the OIG statistician.

Resources

The Division has 22 FTE currently assigned in Washington, Austin, Chicago, and Atlanta. 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 40 enhancements of

the MCI, the OIG's enterprise database. Most notably, the Division implemented a secure intranet platform to store, search, and print OIG policies, procedures, directives, and issues of shared concern. Additionally, the Division developed new MCI modules to track the fugitive felon match, as well as allocations in awards, travel, training, and supplies.

In a test environment, we successfully migrated a portion of the functionality and data in MCI from our current client-server environment to a "web-enabled" *Oracle 9i* database.

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 916,000 times by more than 174,000 visitors. Our most popular reports were downloaded over 74,000 times, providing both timely access to OIG customers and cost avoidance in the reduced number of reports that must be printed and mailed. Our vacancy announcements accounted for an additional 12,700 downloads.

We posted the frequently-requested "Report on Medical Center Sanitation and Follow-up of the Combined Assessment Program Review Kansas City VA Medical Center" in our electronic reading room in compliance with the Electronic Freedom of Information Act. We posted other CAP and audit reports, Office of Investigations press releases, and other OIG publications, including this semiannual report to Congress, on our website.

Information Management, Security, and Departmental Coordination

We actively participate in the development of Departmental policies and programs to improve VA information security, IT accessibility, and Internet resources and utilization. We provided review and feedback on the Department's draft rewrite of the agency's primary security policy, software security guides, remote access policy, mobile code policy, wireless access policy, infrastructure protection proposal, information security officer policies, and a centrally-managed security contract.

Statistical Support

The OIG statistician is part of the technical support team under the direction of the OIG's Chief Information Officer. The OIG statistician is the subject matter expert providing statistical consultation and support to the VA OIG. The statistician provides assistance in planning, designing, and sampling for relevant 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 seven research design and/or sampling plans for proposed audit projects and OHI proactive program evaluations. Additionally, the OIG statistician provided statistical support for all CAP reviews. This support involved preparing and processing the random samples of full-time VAMC employees who were part of the employee survey. The statistician also provided data concerning purchase card use at each facility.

We used an automated survey software package to create a survey of OIG employees to assess their software training needs and interest in/possible use of a telecommuting program. The statistician also completed conversion into electronic format of the current hard-copy CAP review's employee survey and the OIG audit peer review survey. The electronic completion of these two surveys will drastically reduce employee hours needed for data collection and analysis. Two recent CAP employee surveys were done in paper and online formats. In FY 2003, all CAP employee surveys will be

completed exclusively online. In addition, the upcoming dysphagia survey and the energy conservation policy survey were drafted in the survey software package for dissemination during FY 2003. Research supports that respondents tend to provide more accurate information when an electronic medium for communications is used.

Information Technology Training Initiative

We have 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, 131 employees have received 387 days of instructor-led training in Washington, DC, while 97 field employees have received 171 days of training locally.

DATA ANALYSIS SECTION

The Data Analysis Section (DAS) extracts and analyzes data in VA computer files and systems. DAS staff develop proactive computer profiles that search VA computer data for patterns of inconsistent or irregular records with a high potential for fraud and they refer these leads to OIG auditors and investigators for further review.

They conduct reviews that identify invalid or erroneous information in VA computer files that can lead to bad results or erroneous conclusions. They provide automated data processing technical assessments and support to all elements of the OIG and other governmental agencies needing information from VA computer files. They also provide ADP technical support to preaward and postaward OIG audit reviews that assist VA contracting officers in price negotiations and ensure reasonableness of contract prices. The support work provided by the DAS staff is reported in many of the OIG audits, inspections, and investigative cases described in other sections of this report. Significant efforts include:

Mysterious Deaths at VAMC Columbia, Missouri

An investigation into a number of mysterious patient deaths at VAMC Columbia, MO was conducted in 1992. A nurse at the facility was suspected, but the lack of forensic evidence at the time precluded an indictment. Since then, advancements in forensic science provided the OIG with more effective tools in toxicology and the investigation was reopened. DAS was asked to provide information on the administration of a drug called succinylcholine to several of the patients who died under mysterious circumstances. The original suspect was ultimately indicted on ten counts of homicide.

Fugitive Felon Matches

In compliance with recently signed legislation authorizing a computer match of VA records to state and other Federal files, DAS matched felony warrant files from the U.S. Marshals Service and the State of California Department of Justice to seven VA benefit system files. DAS has identified more than 2,000 veteran recipients with active felony warrants.

Data Mining to Detect Potential Fraud in VA Computer Systems

Fraud and other illegal activities committed against VA's programs can amount to millions of dollars. Contracts, procurements, and veterans benefits programs are inherently vulnerable to fraud due to the large expenditures of funds associated with purchasing the items necessary for an agency as large and diverse as VA to operate and for compensating millions of veterans for their service to their country. The DAS staff took a proactive approach to finding and reporting fraud by developing computer profiles that reflect the procedures used to defraud the VA and duplicating

those procedures looking for similar patterns in the data. As a result of their data mining efforts, DAS referred 39 cases of potential fraud to OIG investigators for further review. The cases include a wide variety of benefit fraud such as: suspected deceased payees still receiving VA benefit payments, questionable payments to suspicious addresses, and payments to incarcerated veterans.

Death Match Project

DAS staff is conducting a proactive death match project in cooperation with the OIG Office of Investigations. The match identifies individuals who may be defrauding VA by receiving VA benefit payments sent to deceased veterans. DAS refers the matches to OIG investigators for further review. The file is updated on a recurring basis to obtain more current information. DAS recently added more than 2,700 new cases of potential fraud against VA to the death match database.

Combined Assessment Program - Medical

DAS staff provided technical support and data to 16 CAP reviews focusing on the quality, efficiency, and effectiveness of medical services provided to veterans. Reviews of part-time physician time usage and sanitation issues at the Kansas City Medical Center requested by the Secretary of Veterans Affairs were also included in these reviews.

Combined Assessment Program - Benefits

DAS staff provided technical support and data to three VARO CAP reviews focused on the delivery of monetary benefits to veterans and their dependents.

Preaward and Postaward Contract Reviews

DAS staff provided technical support and data to 11 preaward and postaward contract reviews conducted by the OIG to identify opportunities to negotiate better prices and to disclose overcharges by contract vendors.

Assistance to Other Agencies

DAS staff supported six requests from other agencies for information contained in VA computer files. Agencies included the Department of Justice, SSA, and the U.S. General Accounting Office.

Other Workload

During this reporting period, DAS staff completed 108 ad hoc requests for data requested by all other OIG operational elements. Considerable effort was also expended by DAS in support of a search for additional suspects in the Atlanta fraud case, follow up work on the Philippines review, and other requests having substantial impact on veterans. In one noteworthy case, a veteran who is homeless and without a mailing address since 1995 will receive all of the VA benefit checks that he has been entitled to since that date.

IV. FINANCIAL AND ADMINISTRATIVE SUPPORT DIVISION

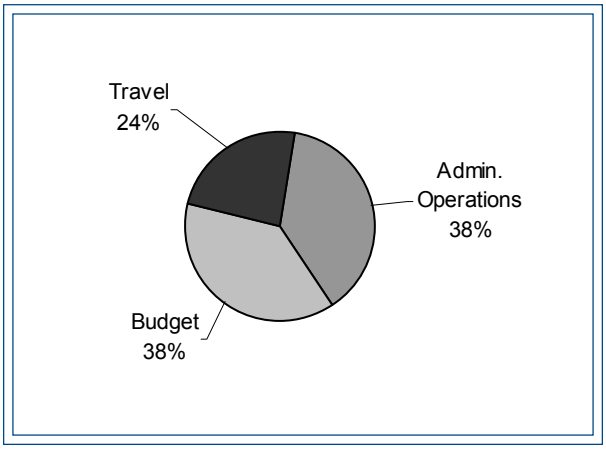
Mission Statement

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. Our services include budget formulation, presentation, and execution; travel processing; procurement; space and facilities management; and general administrative support.

Resources

The Division has eight FTE currently assigned. The staff allocation for the three functional areas is as follows:



Overall Performance

Budget and Finance Section

The staff assisted in the preparation of the FY 2004 budget submission and materials for associated hearings in the Department and OMB.

The budget staff executed 99.36 percent of the OIG's FY 2002 budget authority.

Travel Section

By the nature of our work, OIG personnel travel almost continuously. As a result, we processed 1,848 travel and 93 permanent change of station vouchers in addition to 14 new permanent change of station authorities and 24 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, this component processed 133 procurement actions and reviewed and approved, each month, the 65 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 related support services for the entire OIG. It serves as liaison to the VA Central Office for personnel and payroll related matters.

Resources

The Division has eight FTE, which are all committed to human resources management and support.

Overall Performance

Human Resources Management

During this period, the staff brought 36 new employees on board. In addition, the staff processed 106 personnel actions and 466 awards.

OTHER SIGNIFICANT OIG ACTIVITIES

President's Council on Integrity and Efficiency

- The Assistant Inspector General for Investigations served on a PCIE investigations committee examining the issue of law enforcement authority for special agents of the OIG.

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

- OIG Audit Planning Division staff participated in the PCIE Government Performance and Results Act workgroup. This workgroup is addressing strategic governance issues.

OIG Management Presentations

2002 Association of Directors of Investigation Conference

The Inspector General participated as a member of the IGs' panel. The conference provided an opportunity to discuss how the mission of Federal law enforcement has changed since September 11, 2001. The panel provided an occasion for all attendees to ask questions concerning our new responsibilities and to reflect on the state of the IG community.

Inter-Agency Task Force on Reviewing Biological Agents

The Deputy Assistant Inspector General for Healthcare Inspections briefed an inter-agency task force comprised of auditors and evaluators from the Departments of Agriculture, Defense, and Health and Human Services. He discussed the methods for reviewing the adequacy of security over biological, chemical, and radioactive agents that have the potential of conversion to weapons of mass destruction. The Office of Healthcare Inspections hosted a meeting with this same task force in August 2002. The task force meets quarterly on this very important issue.

10th Annual Leadership VA Alumni Association Forum

The Deputy Assistant Inspector General for Management and Administration represented the IG in a panel discussion of VA leaders at this forum, responding to questions from the VA executives and managers attending.

Presentation at VA INFOSEC 2002 Security Conference

The Central Office Audit Operations Division and security audit project managers participated in a panel discussion on security issues identified during our audit at the National VA Information Security Conference in New Orleans, LA.

Presentations to VHA and VBA on Information Security

The Central Office Audit Operations Division Director and security audit project managers made separate presentations on our security audit findings to VHA and VBA. The presentations included demonstration and discussion of how our

scanning tools are used to complete network vulnerability assessments. The VHA and VBA CIOs requested the presentations to provide a forum for discussion of our security review results.

Presentation to Vice Chairman, President's Critical Infrastructure Protection Board

The Inspector General and staff provided a briefing on our information security initiatives to the Vice Chairman, President's Critical Infrastructure Protection Board. We briefed on the security audit findings and vulnerability areas identified. In response to a request from the Vice Chairman, we coordinated with representatives from the PCIE to provide input to the Board concerning IG community cyber security findings and resources needed to better perform the IG cyber security oversight mission.

Office of Acquisition and Materiel Management's Acquisition Forums

The Counselor to the Inspector General and OIG representatives from the Contract Review and Evaluation Division made four presentations to local contracting personnel. The presentations covered various aspects of local procurements and purchasing practices including use of FSS contracts, contracts with distributors, Government purchase cards, and health care resource proposals.

Office of Acquisition and Materiel Management's Industry Day "Strengthening the Partnership - Building a Firmer Foundation"

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

7th Annual Medicaid Drug Rebate Program

OIG representatives from the Contract Review and Evaluation Division, VA's Office of General Counsel, and the FSS Service conducted a half-day workshop for pharmaceutical industry representatives. The workshop covered the FSS program and the requirements of Public Law 102-585 §603.

National Acquisition Center New Contracting Officer Training

The Director, Contract Review and Evaluation Division and his staff presented an overview of the OIG Contract Review and Evaluation Division to new contracting officers at the National Acquisition Center in Hines, IL. The presentation covered how we conduct preaward and postaward reviews and how we fit into the acquisition process.

Association of Government Accountants

Audit Manager Nicholas Dahl served as President of the Boston Chapter of the Association of Government Accountants for the 2001-2002 program year. Under his leadership, the Boston Chapter received the Platinum Award, the highest level of recognition, for superior chapter accomplishments. The Chapter was also recognized with the National Community Service Award in the large chapter group for its significant involvement in, and commitment to community service.

VBA Assistant Directors Development Program

The Director, Hotline Division, participated in a panel on ethics at the VBA assistant directors development program. He explained the role of the OIG and the Hotline in ethics complaints.

Awards

Letter of Appreciation

Three staff members from the Office of Audit received a letter of appreciation from the Director of Finance for the Palo Alto Institute for Research and Education, Inc. thanking them for their professionalism, focus, and help during an OIG review of the nonprofit research corporation at VAMC Palo Alto, CA. The review was performed to help address questions received from the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs relating to the Department's oversight of VA non-profit research and education corporations. The team consisted of Manuel Mireles, Gregory Gladhill, and Raymond Jurkiewicz.

OIG Congressional Testimony

- In April 2002, the Assistant Inspector General for Auditing testified before the House Committee on Veterans' Affairs. The testimony discussed the OIG's audit work related to inclusion of priority group 7 veterans in VA's veterans equitable resource allocation system.

- In May 2002 and in September 2002, the Assistant Inspector General for Auditing testified before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs. On both occasions the testimony discussed the results of the OIG's work related to VA's nonprofit research and education foundations affiliated with VHA facilities.

- In June 2002, the Deputy Assistant Inspector General for Auditing and the Counselor to the Inspector General testified before the Subcommittee on Health, House Committee on Veterans' Affairs. The testimony discussed procurement practices in VA and H.R. 3645, the Veterans Health Care Items Procurement Reform and Improvement Act 2002.

- In June 2002, the Assistant Inspector General for Auditing testified before the Subcommittee on Health, House Committee on Veterans' Affairs. The testimony discussed the results of our review of Kansas City VA Medical Center.

- In September 2002, the Inspector General testified before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs. The testimony provided OIG's assessment of VA's information security 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				
01-02946-58 4/1/02	Combined Assessment Program Review of the VA San Diego Healthcare System			
01-01518-30 4/4/02	Combined Assessment Program Review of the VA Medical Center Durham, NC	$103,246	$103,246	
01-01516-29 5/28/02	Combined Assessment Program Review of the Department of Veterans Affairs Medical Center Providence, RI			
00-02083-52 5/31/02	Combined Assessment Program Review of the Central Alabama Veterans Health Care System			
02-01165-111 6/7/02	Combined Assessment Program Review of VA Regional Office Cleveland, OH			
01-02639-115 6/12/02	Combined Assessment Program Review of the VA Regional Office Manchester, NH	$18,923	$18,923	
01-02104-116 6/12/02	Combined Assessment Program Review of the VA Regional Office New York, NY	$25,882	$25,882	
02-00970-122 6/21/02	Combined Assessment Program Review of the VA Regional Office Waco, TX	$157,546	$157,546	
01-02122-133 7/10/02	Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System			
00-01219-134 7/10/02	Combined Assessment Program Review of the VA Medical & Regional Office Center Fargo, ND			
01-00223-136 7/16/02	Combined Assessment Program Review of the James H. Quillen VA Medical Center			
01-01073-140 7/19/02	Combined Assessment Program Review of the VA Connecticut Healthcare System			
01-02120-20 7/22/02	Combined Assessment Program Review of the John J. Pershing VA Medical Center Poplar Bluff, MO			

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)				
02-01168-144 7/25/02	Combined Assessment Program Review of the VA Regional Office Des Moines, IA	$13,465	$13,465	
01-02327-149 7/29/02	Combined Assessment Program Review of the Central Texas Veterans Health Care System Temple, TX			
02-01171-108 7/31/02	Combined Assessment Program Review of the VA Long Beach Healthcare System	$1,813,350	$1,813,350	
02-01159-145 8/5/02	Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital Madison, WI	$490,137	$490,137	
02-01259-148 8/6/02	Combined Assessment Program Review of the VA Regional Office Newark, NJ	$9,160	$9,160A	
02-01929-156 9/3/02	Combined Assessment Program Review of the VA Regional Office Roanoke, VA			
01-02940-166 9/20/02	Combined Assessment Program Review of the VA Medical Center Fayetteville, NC	$150,000	$150,000	
02-00988-170 9/30/02	Combined Assessment Program Review of VA Loma Linda Healthcare System	$747,186	$747,186	
02-01766-171 9/30/02	Combined Assessment Program Review of VA Regional Office Denver, CO	$27,500	$27,500	
INTERNAL AUDITS				
00-01089-91 5/8/02	Audit of VA Medical Center Management of Miscellaneous Supply Inventories	$53,700,000	$53,700,000	
00-01088-97 5/17/02	Audit of VA Consolidated Mail Outpatient Pharmacy Inventory Management	$28,800,000	$12,600,000	
01-01463-104 6/3/02	Management Letter, Audit of VA's Fiscal Years 2001 and 2000 Consolidated Financial Statements General Systems Computer Controls Review at the Austin Automation Center			
01-02782-99 6/11/02	Report of Audit of the Department of Veterans Affairs' Franchise Fund Consolidated Financial Statements for Fiscal Years 2001 and 2002			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
INTERNAL AUDITS (Cont'd)				
01-01463-105 6/13/02	Management Letter, Audit of VA's Fiscal Years 2001 and 2000 Consolidated Financial Statements General Systems Computer Controls Review at the Philadelphia Information Technology Center			
01-01463-106 6/13/02	Management Letter, Audit of VA's Fiscal Years 2001 and 2000 Consolidated Financial Statements General Systems Computer Controls Review at the Hines Benefits Delivery Center			
01-01463-107 6/13/02	Management Letter, Audit of VA's Fiscal Years 2001 and 2000 Consolidated Financial Statements Loan Guaranty Systems Control Review at the Austin Automation Center			
01-01463-123 6/21/02	Management Letter, Audit of Department of Veterans Affairs Consolidated Financial Statements for the Fiscal Year Ended September 30, 2001			
02-01202-164 9/12/02	Audit of Department of Veterans Affairs Fiscal Year 2001 Special Disabilities Capacity Report			
00-00061-169 9/30/02	Audit of Veterans Benefits Administration Benefit Payments Involving Unreimbursed Medical Expense Claims	$104,800,000	$104,800,000	
OTHER OFFICE OF AUDIT REVIEWS				
02-00825-78 4/4/02	Attestation of the Department of Veterans Affairs "Detailed Accounting Submission" for Fiscal Year 2002			
02-00198-86 4/16/02	Report on Promptness of Department of Veterans Affairs' Payments to the District of Columbia Water and Sewer Authority			
02-02280-112 6/3/02	Report on Medical Center Sanitation and Follow-up of the Combined Assessment Program Review, Kansas City VA Medical Center			
00-02888-127 7/12/02	Evaluation of Computer and Housekeeping Equipment Accountability at the VA Maryland Health Care System			
02-01265-152 8/21/02	Evaluation of Hotline Complaint Concerning Office Space Furnished to a Government Contractor at the Austin Automation Center			

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)				
01-00236-153 8/26/02	Allegations of Mismanagement in Psychiatry Programs at VA Medical Center Gainesville, FL			
01-00256-157 9/5/02	Evaluation of Business Operations Between the Department of Veterans Affairs and the Federal Energy Regulatory Commission			
CONTRACT REVIEWS *				
00-00218-87 4/16/02	Postaward Review of Hollister Incorporated's Federal Supply Schedule Contract Number V797P-3546j			
00-00957-88 4/17/02	Settlement Agreement, Postaward Review of Cordis Corporation			$1,822,439
02-00799-89 4/22/02	Review of Proposal for CT Scanners and MRI Systems Submitted by GE Medical Systems Under Solicitation Number RFP-M6-Q8-02	$352,500		
02-00658-90 4/23/02	Review of Proposal for Diagnostic X-Ray Systems Submitted by GE Medical Systems Under Solicitation Number M6-Q1-01	$1,224,208		
02-00333-92 5/1/02	Review of Proposal Submitted by the University of California, San Francisco, Under Solicitation Number RFP 261-0258-01, for Anesthesiology Services at the Veterans Affairs Medical Center San Francisco, CA	$25,034		
00-01421-93 5/1/02	Postaward Review of A-Dec Inc.'s Voluntary Disclosure and Refund Offer for Federal Supply Schedule Contract V797P-3688k			$1,496
02-00623-94 5/1/02	Review of Proposal Submitted by the University of Washington Under Solicitation Number RFP V663P-22-02 for Anesthesiology Services at the Department of Veterans Affairs Puget Sound Heath Care System, Seattle Division	$869,558		
02-00643-96 5/2/02	Review of Federal Supply Schedule Proposal Submitted by DeRoyal Industries, Inc. Under Solicitation Number RFP-797-FSS-99-0025	$534,310		

* 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)				
02-01542-102 5/23/02	Review of Medtronic Physio-Control Corporation Pricing Proposal Under Solicitation Number RFP-797-99-0025	$1,784,430		
02-01037-103 5/24/02	Review of Federal Supply Schedule Proposal Submitted by Philips Electronics of North America Under Solicitation Number RFP-797-FSS-99-0025	$2,335,428		
02-00011-113 6/5/02	Review of Proposal Submitted by Mather-McClellan Women's Health Medical Corporation, Under Solicitation Number RFP 261-0134-01, for Gynecology Services at Veterans Affairs Mather Medical Center and McClellan Outpatient Clinic Sacramento, CA	$2,318,190		
02-01036-125 6/25/02	Review of Proposal for Diagnostic X-Ray Systems and Related Equipment, Including Installation, Submitted by Philips Medical Systems North America Company Under Solicitation Number M6-Q1-01	$2,639,838		
01-02822-126 6/26/02	Review of Federal Supply Schedule Proposal Submitted by Johnson & Johnson Health Care Systems, Inc., on Behalf of Lifescan, Inc., Under Solicitation Number M5-Q52D-01	$15,430,800		
00-00490-117 7/1/02	Verification of Endo Pharmaceuticals Inc.'s Self-Audit Under Federal Supply Schedule Contract Number V797P-5286x			$59,951
02-01330-129 7/3/02	Review of Proposal Submitted by Joslin Diabetes Center Under Solicitation Number 101-16-02 for Joslin Vision Network Telemedicine Technology	$1,015,496		
02-00900-131 7/9/02	Review of Siemens Medical Solutions USA, Inc.'s Direct Delivery Proposal for Diagnostic X-ray Systems Under Solicitation Number M6-Q1-01			
01-02285-132 7/9/02	Verification of Spacelabs Medical's Self-Audit Under Federal Supply Schedule Contract Number V797P-3181k			$108,782
02-02157-135 7/9/02	Verification of Axcan Scandipharm Inc.'s Self-Audit Under Federal Supply Schedule Contract Number V797P-5459x			$1,811

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
02-01421-141 7/19/02	Request for Preaward Review of Contra Costa Regional Health Center's Proposal in Response to Request for Proposal Number 261-0049-01			
00-02779-143 7/19/02	Review of Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5629n, Awarded to Ortho Clinical Diagnostics Systems, Incorporated, a Company of Johnson & Johnson, Incorporated			$69,774
02-01195-142 7/22/02	Review of Proposal for Computed Tomography (CT) Scanners and Magnetic Resonance Imaging (MRI) Systems, MRI and CT Upgrades and Accessories, Submitted by Philips Medical Systems North America Company Under Solicitation Number M6-Q8-02	$2,962,755		
99-00087-130 7/25/02	Settlement Agreement, Genzyme Corporation Under Federal Supply Schedule Contract Number V797P-3647k			$521,972
02-01884-146 7/25/02	Review of Proposal for Computed Tomography (CT) Scanners and Magnetic Resonance Imaging (MRI) Systems, MRI and CT Upgrades and Accessories, Submitted by Siemens Medical Solutions USA, Incorporated Under Solicitation Number M6-Q8-02			
02-00007-150 8/7/02	Verification of CD Acquisition Holding Inc.'s Self-Audit Under Federal Supply Schedule Contract Number V797P-5140n			$700,000
02-02605-151 8/15/02	Review of Proposal Submitted by University Medical Associates Under Solicitation Number 636-04-02 for Nephrology Services at Department of Veterans Affairs Medical Center Omaha, NE	$261,109		
02-01775-154 8/27/02	Review of Proposal for Diagnostic X-ray Systems and Related Equipment, Including Installation, Submitted by Fujifilm Medical Systems USA, Inc. Under Solicitation Number M6-Q1-01	$576,777		
99-00109-155 8/27/02	Postaward Review of Invacare Corporation			$472,693
00-00259-161 9/5/02	Review of Federal Supply Schedule Proposal Submitted by Buffalo Supply, Inc. Under Solicitation Number 797-FSS-99-0025			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
01-00358-163 9/10/02	Review of Ernst & Young LLP's Analysis of Overcharges on J&J Orthopaedic Inc.'s Federal Supply Schedule Contract V797P-3642j			$586,484
ADMINISTRATIVE INVESTIGATIONS				
01-02888-84 4/8/02	Administrative Investigation, Acceptance of Pharmaceutical Samples Issue, VA Medical Center Chillicothe, OH			
02-00136-85 4/15/02	Administrative Investigation, Improper Promotion Issue, VA Medical Center West Palm Beach, FL			
02-01779-109 6/3/02	Administrative Investigation, Leadership Issues Relating to Cleanliness and Sanitation Conditions, Kansas City VA Medical Center and VISN 15, Kansas City, MO			
01-02888-114 6/7/02	Administrative Investigation, Acceptance of Pharmaceutical Samples Issue, VHA Central Office			
01-02807-158 8/30/02	Administrative Investigation - Physician Time and Attendance Issue, Central Texas Veterans Health Care System Temple, TX			
HEALTHCARE INSPECTIONS				
01-00026-18 4/16/02	Healthcare Inspection, Controlled Substances Prescribed to Patients in Veterans Health Administration Mental Health and Behavioral Sciences Programs			
02-00824-95 5/7/02	Healthcare Inspection, Patient Care Issues, William Jennings Bryan Dorn Veterans Affairs Medical Center Columbia, SC			
01-02863-98 5/8/02	Healthcare Inspection, Patient Care Issues, Richard L. Roudebush VA Medical Center Indianapolis, IN			
02-00249-100 5/14/02	Healthcare Inspection, Customer Service and Personnel Matters at the Department of Veterans Affairs Community-Based Outpatient Clinic Prestonsburg, KY			
02-01331-110 6/3/02	Healthcare Inspection, Quality of Care Issues, Department of Veterans Affairs Medical Health Care System, Perry Point, MD			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
HEALTHCARE INSPECTIONS (Cont'd)				
01-00026-101 6/10/02	Healthcare Inspection, Veterans Health Administration Pain Management Initiative			
02-00838-118 6/12/02	Healthcare Inspection, Quality of Care Issues Veterans Affairs Healthcare System, El Paso, TX			
02-00705-121 6/13/02	Employee Conduct Issues, Central Arkansas Veterans Healthcare System, Little Rock, AR			
02-00821-120 6/14/02	Healthcare Inspection, Missing Patient Issue VA Greater Los Angeles Healthcare System, Los Angeles, CA			
02-00130-119 6/17/02	Healthcare Inspection, Patient Treatment Issues Northern Arizona VA Health Care System, Prescott, AZ			
01-00886-124 6/25/02	Healthcare Inspection, National Practitioner Data Bank Reporting Issues, Department of Veterans Affairs Medical Center, Dayton, OH			
01-00127-128 7/1/02	Healthcare Inspection, Patient Care and Management Issues, Department of Veterans Affairs Medical Center, Northport, NY			
02-00279-138 7/16/02	Healthcare Inspection, Patient Treatment and Employee Behavior Issues, Department of Veterans Affairs Medical Center West Palm Beach, FL			
01-02864-137 7/18/02	Healthcare Inspection, Discharge Planning Issues Veterans Affairs Medical Center, Cheyenne, WY			
01-01512-139 7/18/02	Healthcare Inspection, Alleged Inappropriate Transfers of Patients in Veterans Integrated Service Network 12			
01-01090-147 8/5/02	Healthcare Inspection, Patient Care and Management Issues Central Alabama Veterans Health Care System,Tuskegee, AL			
02-02121-159 9/3/02	Healthcare Inspection, Patient Anesthesia Care Issues, Southern Arizona VA Health Care System, Tucson, AZ			
02-02160-160 9/4/02	Healthcare Inspection, Work Environment Issue, Southern Arizona VA Health Care System,Tucson, AZ			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
HEALTHCARE INSPECTIONS (Cont'd)				
02-02108-162 9/9/02	Healthcare Inspection, Review of Prescription Practices at VA Medical Centers, West Palm Beach and Miami, Florida			
02-01837-165 9/11/02	Healthcare Inspection, Management of Patient Funds VA Puget South Health Care System, Seattle, WA			
01-02036-167 9/17/02	Healthcare Inspection, Cardiac Catheterization Laboratory Issue, Central Arkansas Veterans Healthcare System, Little Rock, AR			
02-02369-168 9/18/02	Healthcare Inspection, Quality Care Issues Missouri Veterans Home, St. Louis, MO			
TOTAL:	**95 Reports**	**$223,186,828**	**$174,656,395**	**$4,345,402**

APPENDIX B

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	58
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-66
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-66
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	82 (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	82 (App. B)
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	71-79 (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	83 (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	84 (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	82 (App. B)
Section 5 (a) (11)	Significant revised management decisions	97 (App. B)
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	82 (App. B)
Section 5 (a) (13)	Information described under section 05(b) of the Federal Financial Management Improvement Act of 1996 (Public Law 104-208)	82 (App. B)

INSPECTOR GENERAL ACT REPORTING REQUIREMENTS (CONT'D)

Prior Significant Recommendations Without Corrective Action and Significant Management Decisions

The IG Act requires identification of: (i) prior significant recommendations on which corrective action has not been completed, (ii) significant revised management decisions, and (iii) 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 these sections of 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 2001 and 2000 (Report Number 01-01463-69, dated February 27, 2002), 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 as of the end of this reporting period. The following lists the contract review unresolved reports for which a contracting officer decision has not been made for over 6 months.

> Review of FSS Proposal Submitted by Omnicell, Inc., Under Solicitation Number RFP-797-FSS-99-0025; Report No. 01-00460-39; Issued 1/31/01.
>
> 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.

These reports will be closed after the OIG receives the contracting officer price negotiation memorandum (PNM) following contract awards. The PNMs for these reviews are anticipated by December 2002.

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 3/31/02	0	$0
Issued during reporting period	10	$4.3
Total Inventory This Period	**10**	**$4.3**
Management decision during reporting period		
Disallowed costs (agreed to by management)	10	$4.3
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Period	**10**	**$4.3**
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 3/31/02	13	$5.9
Issued during reporting period	28	$223.2
Total Inventory This Period	**41**	**$229.1**
Management decisions during reporting period		
Agreed to by management	28	$203.2
Not agreed to by management	5	$5.6
Total Management Decisions This Period	**33**	**$208.8**
Total Carried Over to Next Period	**8**	**$20.3**

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 C

OIG OPERATIONS PHONE LIST

Investigations

Central Office Investigations Washington, DC ..... (202) 565-7702
Northeast Field Office (51NY) New York, NY ..... (212) 807-3444
Boston Resident Agency (51BN) Bedford, MA ..... (781) 687-3138
Newark Resident Agency (51NJ) Newark, NJ ..... (973) 297-3338
Pittsburgh Resident Agency (51PB) Pittsburgh, PA ..... (412) 784-3818
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Houston Resident Agency (51HU) Houston, TX ..... (713) 794-3652
New Orleans Resident Agency (51NO) New Orleans, LA ..... (504) 619-4340
Western Field Office (51LA) Los Angeles, CA ..... (310) 268-4268
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)

Healthcare Inspections

Central Office Operations Washington, DC ..... (202) 565-8305
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, GA ..... (718) 687-2134
Healthcare Regional Office Chicago (54CH) Chicago, IL ..... (708) 202-2672
Healthcare Regional Office Dallas (54DA) Dallas, TX ..... (214) 655-6000
Healthcare Regional Office Los Angeles (54LA) Los Angeles, CA ..... (310) 268-3005

Audit

Central Office Operations Washington, DC ..... (202) 565-4625
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Operations Division Bedford (52BN) Bedford, MA ..... (781) 687-3120
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APPENDIX D

GLOSSARY

A&MM	Acquisition and Materiel Management
BDN	Benefits Delivery Network
C&P	Compensation and Pension
CAP	Combined Assessment Program
CAT	Computerized Axial Tomography
CFS	Consolidated Financial Statements
CIO	Chief Information Officer
CMOP	Consolidated Mail Outpatient Pharmacies
CRNA	Certified Registered Nurse Anesthetist
DAS	Data Analysis Section
DIC	Dependency and Indemnity Compensation
DoD	Department of Defense
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
HHA	Home Health Agency
HRA	Office of Human Resource and Administration
HUD	Department of Housing and Urban Development
IG	Inspector General
I&T	Office of Information and Technology
IT	Information Technology
IVM	Income Verification Match
MCCF	Medical Care Cost Funds
MCI	Master Case Index
MGT	Office of Management
NCA	National Cemetery Administration
NHCU	Nursing Home Care Unit
NPDB	National Practitioner Data Bank
OGC	Office of General Counsel
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
OMB	Office of Management and Budget
P&P	Office of Policy and Planning
PNM	Price Negotiation Memorandum
SSA	Social Security Administration
U.S.	United States
UME	Unreimbursed Medical Expense
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VAM&ROC	Veterans Affairs Medical & Regional Office Center
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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810 Vermont Avenue, NW
Washington, DC 20420

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Cover photo of Illinois Korean War Memorial
Oak Ridge Cemetery
Springfield, IL by
Joseph M. Vallowe, Esq.
VA OIG, Washington, DC

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E-mail Address:	**vaoighotline@mail.va.gov**

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

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