Office of Inspector General
Department of Veterans Affairs

Semiannual Report to Congress
October 1, 2003 - March 31, 2004

FOREWORD

I am pleased to submit the semiannual report on the activities of the Department of Veterans Affairs (VA), Office of Inspector General (OIG) for the period ended March 31, 2004. This report is issued in accordance with the provisions of the Inspector General Act of 1978, as amended. The OIG is dedicated to helping ensure that veterans and their families receive the care, support, and recognition they have earned through service to our country.

A total of 118 reports on VA programs and operations resulted in systemic improvements and increased efficiencies in areas of medical care, benefits administration, procurement, financial management, and information technology. Audits, investigations, and other reviews identified over $1.9 billion in monetary benefits, for an OIG return on investment of $57 for every dollar expended.

Our criminal investigators closed 502 investigations involving a wide variety of criminal activity directed at VA personnel, patients, programs, or operations. Special agents conducted investigations that led to 616 arrests, indictments, convictions, and pretrial diversions. They also produced $18.2 million in monetary benefits to VA (recoveries and savings). Additionally, the efforts of our agents led to the apprehension of 149 fugitive felons nationwide.

One of our more significant investigations involved a former chief research coordinator at the Veterans Affairs Medical Center (VAMC) Albany, NY, who has been charged in a 48-count felony indictment for criminally negligent homicide, manslaughter, and fraud for falsifying veterans' medical records in order to enroll them in cancer research studies sponsored by private pharmaceutical companies. The indictment followed an investigation that revealed the researcher's alterations, forgeries, and false statements pertaining to the official records led to the 2001 death of a veteran who had sought treatment for gastric cancer. The researcher allegedly falsified blood tests, switched the records of potential research patients with other patients, and doctored lab reports to camouflage the fraud. The investigation also revealed that the researcher was dismissed from medical school for falsifying transcripts in 1984, was convicted of mail fraud for falsifying information on a medical license application in 1992, and had lied on his federal employment application regarding his undergraduate performance and mail fraud conviction. The investigation is ongoing and could result in charges being filed against additional subjects.

Audit oversight focused on determining how to improve VA services to veterans and their families. Our follow-up audit of part-time physician time and attendance showed that Veterans Health Administration's (VHA's) implementation of management controls continues to need improvement to ensure that all part-time physicians meet their employment obligations. An audit of VAMCs' procurement of medical, prosthetic, and miscellaneous operating supplies found that VA could reduce supply costs by up to $1.4 billion over 5 years by using contract sources more effectively and by awarding more national-scope contracts. Also, preaward and postaward contract reviews identified monetary benefits of about $538 million resulting from actual or potential contractor overcharges to VA. Contract review recoveries have resulted in significant returns to VA's revolving supply fund.

Our health care inspectors focused on quality of care issues in VA. Inspectors visited a number of facilities to respond to Congressional and other special requests concerning health care related matters. We also completed two summary evaluation reports that should assist VHA managers in improving VA medical facility potable and waste water systems security, and the quality of care provided to patients and maximize the use of resources in the homemaker and home health aide program. If VHA had established benchmark rates as recommended in a 1997 OIG report, the program could have redirected about $10.7 million annually to treat additional patients.

Our Hotline provides an opportunity for employees, veterans, and other concerned citizens to report criminal activity, waste, abuse, and mismanagement. The reporting of such issues is integral to the goal of improving the efficiency and effectiveness of the Government. During the reporting period, the Hotline received 13,976 contacts and opened 546 cases. Analysts closed 513 cases, of which 166 (32 percent) contained substantiated allegations. The monetary impact resulting from these cases totaled almost $960,000.

The OIG's ongoing Combined Assessment Program (CAP) evaluates the quality, efficiency, and effectiveness of VA facilities. Through this program, auditors, investigators, and health care inspectors collaborate to assess key operations and programs at VA medical centers and VA regional offices on a cyclical basis. The 23 CAP reviews and 3 CAP summary reviews completed during this reporting period highlighted numerous opportunities for improvement in quality of care, management controls, and fraud prevention.

I 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 March 31, 2004. The following statistical data highlights OIG activities and accomplishments during the reporting period.

DOLLAR IMPACT	**Dollars in Millions**
Funds Put to Better Use	$1,940.0
Dollar Recoveries	$19.7
Fines, Penalties, Restitutions, and Civil Judgments	$7.8

RETURN ON INVESTMENT	
Dollar Impact ($1,967.5) / Cost of OIG Operations ($34.3)	57 : 1

OTHER IMPACT	
Arrests	286
Indictments	161
Convictions	158
Pretrial Diversions	11
Fugitive Felon Apprehensions	149
Administrative Sanctions	260

ACTIVITIES	
Reports Issued	
Combined Assessment Program (CAP) Reviews	23
CAP Summary Reviews	3
Joint Review	1
Audits	12
Contract Reviews	56
Healthcare Inspections	16
Administrative Investigations	7
Investigative Cases	
Opened	498
Closed	502
Healthcare Inspections Activities	
Clinical Consultations	8
Hotline Activities	
Contacts	13,976
Cases Opened	546
Cases Closed	513

OFFICE OF INVESTIGATIONS

Overall Focus

The Criminal Investigations Division focuses its resources on investigations that have the highest impact on the programs and operations of the Department. While continuing to target traditional "white collar" criminal activity associated with the operations of VA, personnel of the Criminal Investigations Division more frequently find themselves involved in the investigation of violent criminal activity such as murder, armed robbery, terroristic or other threats -- all of which are occurring on VA property and/or directed at VA personnel, patients, programs, or operations.

The Administrative Investigations Division concentrates its resources on investigating allegations against high-ranking VA officials relating to misconduct and other matters of interest to Congress and the Department.

The Analysis and Oversight Division provides guidance and support for the Office of Investigations by conducting routine office inspections and by directing efforts to identify and develop new initiatives designed to enhance the abilities of investigators to accomplish the core mission in a more effective and efficient manner. The Division is also responsible for facilitating personnel training and equipment procurement.

During this semiannual period, the Criminal Investigations Division closed 502 investigations resulting in 330 judicial actions (indictments, convictions, and pretrial diversions) and $18.2 million recovered or saved. Investigative activities resulted in the arrest of 286 individuals who had committed crimes directed at VA programs and operations or crimes that were committed on VA property. In addition, VA OIG investigations led to the apprehension of 149 fugitive felons nationwide. Criminal investigations also resulted in 192 administrative sanctions. The Administrative Investigations Division closed 12 cases, issuing 7 reports and 2 advisory memoranda. These investigations resulted in management agreeing to take 28 administrative sanctions, including personnel actions against 9 officials, and corrective actions in 19 situations that will improve VA operations. The Analysis and Oversight Division completed the inspection of the OIG Southeast Field Office and its four resident agencies.

Veterans Health Administration (VHA)

Two individuals, a mother and daughter, are pending sentencing after pleading guilty to an indictment charging them with conspiracy, theft in connection with health care, mail, and wire fraud. The judicial action followed a joint investigation with the Federal Bureau of Investigation (FBI) that revealed the two co-conspirators devised and executed a scheme in which they stole checks payable to a VAMC. The mother, a VAMC employee, was responsible for the receipt and application of medical reimbursements to veterans' accounts and selectively stole reimbursement checks. She concealed the theft by closing the accounts of veterans whose payments she had stolen. She then provided the stolen checks to her daughter who negotiated them through her purported business account. As a result of their scheme, the VAMC lost approximately $718,000.

Austin American-Statesman
Austin, TX
Friday, February 20, 2004

CASE: Psychiatrist avoids jail, but medical license is in jeopardy

Ralph Barrera

After the verdict, Austin psychiatrist Gregory Vagsherian, center, met to decipher the ruling with his defense team, including Courtney Newton, right, and Charles Burton, who checked the Texas penal code.

Continued from A1

Austin. Two testified that Vagsherian performed sudden and unwanted oral sex on them after hernia examinations. Another testified that Vagsherian gave him lengthy prostate examinations.

Prosecutor Joe Maida IV argued that the tests were not done out of medical necessity but for Vagsherian's sexual satisfaction. The male patients, all veterans, had sought treatment from Vagsherian for mental health problems. Because of the nature of the allegations, the former patients were not identified during the trial.

"We fought hard for the vets, and we felt we put on the best case we could," Maida, wearing a look of disbelief, said outside the courtroom.

Vagsherian appeared confused after the verdict, asking his lawyers at one point, "Is that good news?" He later held several family members, including his wife, Athena, in long embraces before leaving the courtroom without commenting.

Vagsherian was fired by Vet- Affairs medical D- during the trial, under the penal code

"compulsive, spur of the moment" acts and not, in his opinion, what the Legislature had in mind when they wrote the sexual assault law.

The language governing doctors was added along with similar language about clergy members in 1996. The law does not define emotional dependency.

"When you hear some medical person exploited the patients' emotional dependency, what comes to mind for me is these cases where some psychiatrist meets for some time with some female patient and says part of your therapy would be these sexual acts," Wisser said during the phone interview.

Austin psychiatrist Deborah Peel, who had no connection to the case, called Wisser's ruling an outrage. She said emotional dependency is virtually automatic at the outset of any psychiatrist-patient relationship.

"By definition, a relationship where you seek help is one of dependency," said Peel, a past president of the Texas Society of Psychiatric Physicians.

"The idea that the judge would

forensic psychiatry services at Baylor College of Medicine in Houston, said that one of the patients had been seeking therapy for years and developed no particular bond with Vagsherian. That patient needed Vagsherian more to get his prescriptions refilled than for counseling, he testified.

That patient, who was the first to complain to Austin authorities about Vagsherian, testified that after the psychiatrist performed oral sex on him he returned for a subsequent visit with a hidden tape recorder.

That tape was played at trial. Maida argued that the tape proved Vagsherian's guilt because Vagsherian didn't react with surprise when the patient mentioned oral sex.

Scarano testified that the other two former patients suffered from "a group delusion," coming forward with similar stories of sexual assault after the original patient's claims were made public.

One of those two saw Vagsherian four times for a total of one hour, Wisser said that was

After a year-long investigation and a 6-day trial, a former VA out-patient clinic psychiatrist was convicted of nine misdemeanor counts of assaulting three patients under his care. Expert testimony was provided by VA psychiatrists and a noted forensic psychiatrist. From April 1993 to May 2001, the doctor was employed by VA. Testimony from the victims and experts revealed the doctor sexually exploited the doctor-patient relationship. As a result of the local media coverage of this trial, several new alleged victims of the doctor have come forward and made complaints to VA officials and the sex crimes division of the local police department. The information is being evaluated by the county district attorney's office. The subject was sentenced to pay a fine of $4,500. Additionally, the assistant district attorney is preparing a judgment that will be forwarded to the state board of medical examiners, which is expected to terminate the subject's license to practice medicine in the state. Due to a reciprocal agreement, the medical board of a second state is expected to also terminate the subject's license in that state. In addition, tort claims of over $15 million have been filed by at least three former patients. The claims are being handled by the U.S. Attorney's Office.

Veterans Benefits Administration (VBA)

An attorney, appointed as the fiduciary for an incompetent veteran, and his legal secretary, were indicted for criminal acts relating to his duties as a fiduciary. The Federal charges included misappropriation of monies, conspiracy to commit theft of Government funds, mail fraud, money laundering, and conspiracy to launder money. The state charged them with felonious embezzlement. The joint VA OIG, FBI, Internal Revenue Service, and local sheriff's office investigation disclosed the attorney embezzled more than $300,000 from a disabled veteran's account and also wrongfully cashed a $163,170 certificate of deposit held in the guardianship account. The legal secretary allegedly wrote checks and kept the books relative to the

veteran's account and filed false annual accountings with VA. The attorney was recently convicted in an unrelated bank fraud and is awaiting sentencing on that matter. His license to practice law has been suspended by the state bar.

An individual pled guilty in a state court to forging a bank instrument and was sentenced to 5 years' probation. The plea and sentence followed an extensive investigation conducted jointly by VA OIG, Secret Service, Railroad Retirement Board, Internal Revenue Service, and Social Security Administration (SSA) OIG agents. From 1999 to 2000, the individual and three other co-defendants, who are still pending Federal grand jury action, participated in a scheme to intercept over 3,000 benefit checks intended for VA, SSA, and Railroad Retirement pensioners living in Mexico. The checks were intercepted in Mexico City, the central distribution point for all pensioners living within Mexico. These checks were then sent back to the United States via courier to a privately owned supermarket where the recipients' signatures were forged and the checks processed through the business accounts of the supermarket. Loss to VA and other Federal agencies was in excess of $3.5 million.

Fugitive Felon Program

To date, approximately 1.8 million felony warrant files have been received from the participating agencies. These warrant files were matched to more than 11 million records contained in VA benefit system files, resulting in the identification of more than 27,000 matched records. The records match has resulted in over 10,300 referrals of information from VA files about fugitive felons to various law enforcement agencies throughout the country. The information provided to the agencies has directly led to the apprehension of 324 fugitive felons; 195 of these arrests were made with the direct assistance of VA OIG agents. Over 6,500 fugitive felons identified in these matches have been referred to VBA for benefit suspension resulting in the identification of $46.8 million in overpayments and a cost avoidance of over $100 million.

During this reporting period, there were 149 fugitives apprehended as a result of VA OIG agents directly assisting law enforcement or by sharing our information with law enforcement. There were also 4,236 administrative actions referred to VBA for benefit suspension with an identification of $32 million in overpayments and a cost avoidance of $55.8 million.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for $1.9 Billion

Audits and evaluations were focused on operations and performance results to improve service to veterans. Contract preaward and postaward reviews were conducted to assist contracting officers in price negotiations and to ensure reasonableness of contract prices. During this reporting period, 95 audits, evaluations, CAP reviews, CAP summary reviews, and contract preaward and postaward reviews were conducted. An audit of VAMCs' procurement of medical, prosthetic, and miscellaneous operating supplies found that VA could reduce supply costs by up to $1.4 billion over 5 years by using contract sources more effectively and by awarding more national-scope contracts. Also, preaward and postaward contract

reviews identified monetary benefits of about $538 million resulting from actual or potential contractor overcharges to VA.

Veterans Health Administration

Our unannounced follow-up audit of part-time physician time and attendance showed that VHA's implementation of management controls over part-time physician time and attendance continues to need improvement to ensure that part-time physicians meet their employment obligations. Also, an audit of VHA-reported medical care waiting lists showed that the waiting lists were not accurate.

Office of Management

The audit of VA's Consolidated Financial Statements for FYs 2003 and 2002 resulted in an unqualified opinion. The report on internal control discusses two material weaknesses involving: (i) inadequate information technology security controls, and (ii) lack of an integrated financial management system. The report also discusses two reportable conditions that, while not considered material weaknesses, are significant system or control weaknesses that could adversely affect the recording and reporting of the Department's financial information. The two conditions are: (i) loan guaranty business process, and (ii) application program and operating system change controls.

Office of Information Technology

An audit of VA information security controls and security management reported that VA has made insufficient progress in improving its information security posture. The VA is not in compliance with the requirements of the Federal Information Security Management Act. The audit found that significant information security vulnerabilities continue to place VA at risk of: (i) denial of service attacks on mission critical systems, (ii) disruption of mission critical systems, (iii) unauthorized access to and improper disclosure of data subject to Privacy Act protection and sensitive financial data, (iv) fraudulent disbursements from VA benefit payment systems, and (v) fraudulent receipt of health care benefits. Also, an audit of the installation of the Microsoft Blaster Worm virus security patch confirmed that VA computers were not effectively and timely patched.

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. The OHI inspectors reviewed health care issues and made 59 recommendations and 59 suggestions to improve operations, activities, and the care and services provided to patients.

Inspection of the Homemaker and Home Health Aide Program found that patients enrolled in the program did not always meet clinical eligibility requirements. Initial patient assessments by clinicians rarely included

documentation of actual evaluations by all required interdisciplinary team members and did not thoroughly document patients' disabilities, dependencies, and need for services. Some facilities had many patients on waiting lists and did not always consider eligibility or patients' needs. To enhance controls, VA managers need to issue policy for the provision and acquisition of program services to improve the quality of care and to maximize the use of resources. VHA managers also need to establish a method of benchmarking rates for the acquisition of program services. If VHA had established benchmark rates as recommended in a 1997 OIG report, the program could have, on average, redirected about $10.7 million annually to treat additional patients.

Inspection of efforts to safeguard VHA potable and waste water systems identified varying degrees of effort by VHA facilities in conducting water system assessments and security reviews. No facility reported that it coordinated these efforts with the Environmental Protection Agency (EPA) or the Department of Homeland Security. The Under Secretary for Health needs to standardize security requirements for protecting water infrastructures and coordinate efforts with EPA to assess and implement security of potable and waste water systems on VHA properties. These efforts would assist the Department of Homeland Security in unifying efforts for addressing national water infrastructure concerns, including development of critical infrastructure personnel surety programs.

In responding to Congressional and other special requests and reviewing patient allegations pertaining to quality of care issues received by the OIG Hotline, OHI completed 16 Hotline cases, reviewed 78 issues, and made 52 recommendations. These recommendations resulted in managers issuing new and revised procedures, improving services, improving quality of patient care, and making environmental and safety improvements. The OHI assisted the Office of Investigations on eight criminal cases that required extensive review of medical records and quality assurance documents, and monitored the work of VHA's Office of the Medical Inspector.

OFFICE OF MANAGEMENT AND ADMINISTRATION

Hotline

Our Hotline provides an opportunity for employees, veterans, and other concerned citizens to report criminal activity, waste, abuse, and mismanagement. During the reporting period, the Hotline received 13,976 contacts and opened 546 cases. Analysts closed 513 cases, of which 166 (32 percent) contained substantiated allegations. The monetary impact resulting from these cases totaled almost $960,000. The Hotline staff wrote 82 responses to inquiries received from Members of the Senate and House of Representatives. The closed cases led to 40 administrative sanctions against employees and 81 corrective actions taken by management to improve VA operations and activities. Examples of some of the issues addressed by the Hotline include: quality of care, benefits, facilities and services, employee misconduct, and privacy/Health Insurance Portability and Accountability Act.

Follow Up on OIG Reports

The Operational Support Division continually tracks VA staff actions to implement recommendations made in OIG audits, inspections, and reviews. As of March 31, 2004, there were 89 open OIG reports containing 329 unimplemented recommendations with over $2.04 billion of actual or potential monetary benefits. During this reporting period, we closed 89 reports and 395 recommendations, with a monetary benefit of $807 million, after obtaining information that VA officials had fully implemented corrective actions.

Status of OIG Reports Unimplemented for Over 1 Year

The Federal Acquisition Streamlining Act of 1994 provides guidance on prompt management decisions and implementation of OIG recommendations. It states a Federal agency shall complete final action on each recommendation in an OIG report within 12 months after the report is finalized. If the agency fails to complete final action within this period, the OIG will identify the matter in their semiannual report to Congress. There are seven OIG reports issued over one year ago (March 31, 2003, and earlier) with unimplemented recommendations. Four of these are VHA reports; one is a joint report with recommendations for VHA and Office of Security and Law Enforcement, Office of Policy, Planning, and Preparedness; one is a joint report with recommendations for VHA and Office of Information and Technology; and one is a VBA report. The OIG is particularly concerned with one report on VHA operations (issued in 1997) and one report on VBA operations (issued in 2000) with recommendations that still remain open. Details about these reports can be found in Appendix B.

JOINT REVIEW

Interim Report of VAMC Bay Pines, FL

We received requests from the Secretary of Veterans Affairs and Congressional members to review allegations questioning the adequacy of clinical and administrative activities at the VAMC Bay Pines. We issued the interim report to disclose the progress of the review. This review was conducted jointly by OIG investigators, auditors, and health care inspectors. When we have completed our review of the allegations, we will issue a final report. Our review found that VAMC managers cancelled surgeries because critical surgical supplies and instruments were not consistently available or properly sterilized by supply processing and distribution. Other deficiencies identified included improper sterilization procedures, inadequate inventory practices, and poorly trained staff. Our review also showed that VA Core Financial and Logistics System (CoreFLS) project managers still have significant work to do to implement the CoreFLS system. CoreFLS issues on data conversion, testing, training, interfacing with other VA systems, information security, and contracting processes need management attention. This is an interim disclosure report and, as such, there are no recommendations. We will include them in the final report when we complete the review.

VA AND OIG MISSION, ORGANIZATION, AND RESOURCES

The Department of Veterans Affairs

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 our 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 income and readjustment 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; and Acquisition and Materiel Management [A&MM]);
- Information and Technology (I&T);
- Policy, Planning, and Preparedness (Policy; Planning; and Security and Law Enforcement [S&LE]);

- Human Resources and Administration (Diversity Management and Equal Employment Opportunity; Human Resources Management; Administration; and Resolution Management);
- Public and Intergovernmental Affairs; and
- Congressional and Legislative Affairs.

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

Resources

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For FY 2004, VA had approximately 218,000 employees and a $62.1 billion budget. There are an estimated 25.2 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 201,000 of VA's employees work in VHA. Health care was funded at over $28.9 billion in FY 2004, approximately 47 percent of VA's budget. VHA provided care to an average of 57,000 inpatients daily. During FY 2004, there were almost 54 million episodes of care for outpatients. There were 158 medical centers, 133 nursing home units, 206 veterans centers, 42 VA residential rehabilitation treatment programs (formerly called "domiciliaries"), and 867 outpatient clinics (including hospital clinics).

Veterans benefits were funded at $32.1 billion in FY 2004, about 52 percent of VA's budget. Approximately 13,000 VBA employees at 57 VA regional offices (VAROs) provided benefits to veterans and their families. Almost 2.9 million veterans and their beneficiaries receive compensation benefits valued at $26.3 billion. Also, $3.4 billion in pension benefits are provided to approximately 562,000 veterans and survivors. VA life insurance programs have 7.5 million lives insured, with a face value of almost $747.6 billion. Approximately 350,000 home loans will be guaranteed in FY 2004, with a value of approximately $47 billion.

The NCA operates and maintains 120 cemeteries and employs over 1,500 staff in FY 2004. Operations of NCA and all of VA's burial benefits account for approximately $419 million of VA's budget. Interments in VA cemeteries continue to increase each year, with 90,700 projected for FY 2004. Approximately 338,000 headstones and markers will be provided for veterans and their eligible dependents in VA and other Federal cemeteries, state veterans' cemeteries, and private cemeteries.

VA Office of Inspector General (OIG)

Background

VA's OIG was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent

organization. In October 1978, the Inspector General Act (Public Law 95-452) was enacted, establishing a statutory Inspector General (IG) in VA.

Role and Authority

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

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

Organization

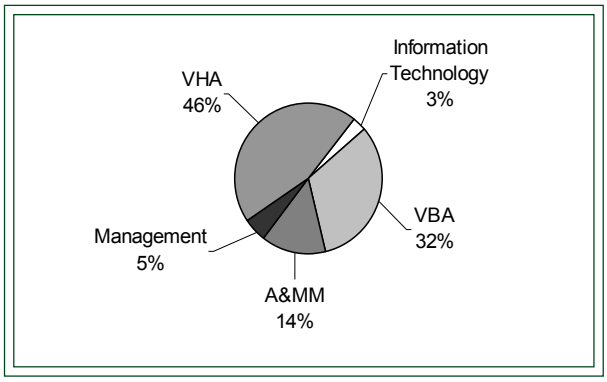
Allocated full-time equivalent (FTE) employees from appropriations for the FY 2004 staffing plan as follows.

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

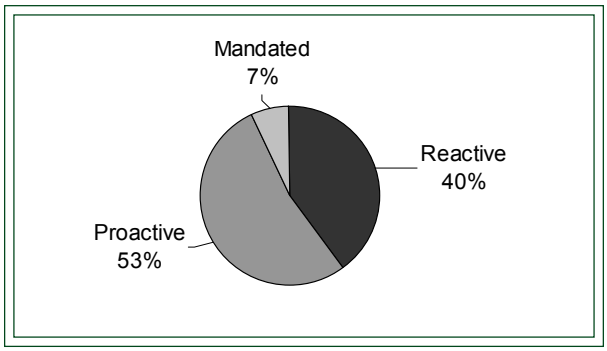
In addition, 25 FTE are reimbursed for a Department contract review function.

The FY 2004 funding for OIG operations was enacted as a 2-year appropriation that provides the funds to remain available until September 30, 2005. The FY 2004 funding of OIG operations is $68.4 million, with $61.6 million from appropriations, $3.8 million from FY 2003 carryover, and $3.0 million through reimbursable agreement. Approximately, 73 percent of the total funding is for salaries and benefits, 5 percent for official travel, and the remaining 22 percent for all other operating expenses such as contractual services, rent, supplies, and equipment.

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



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



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

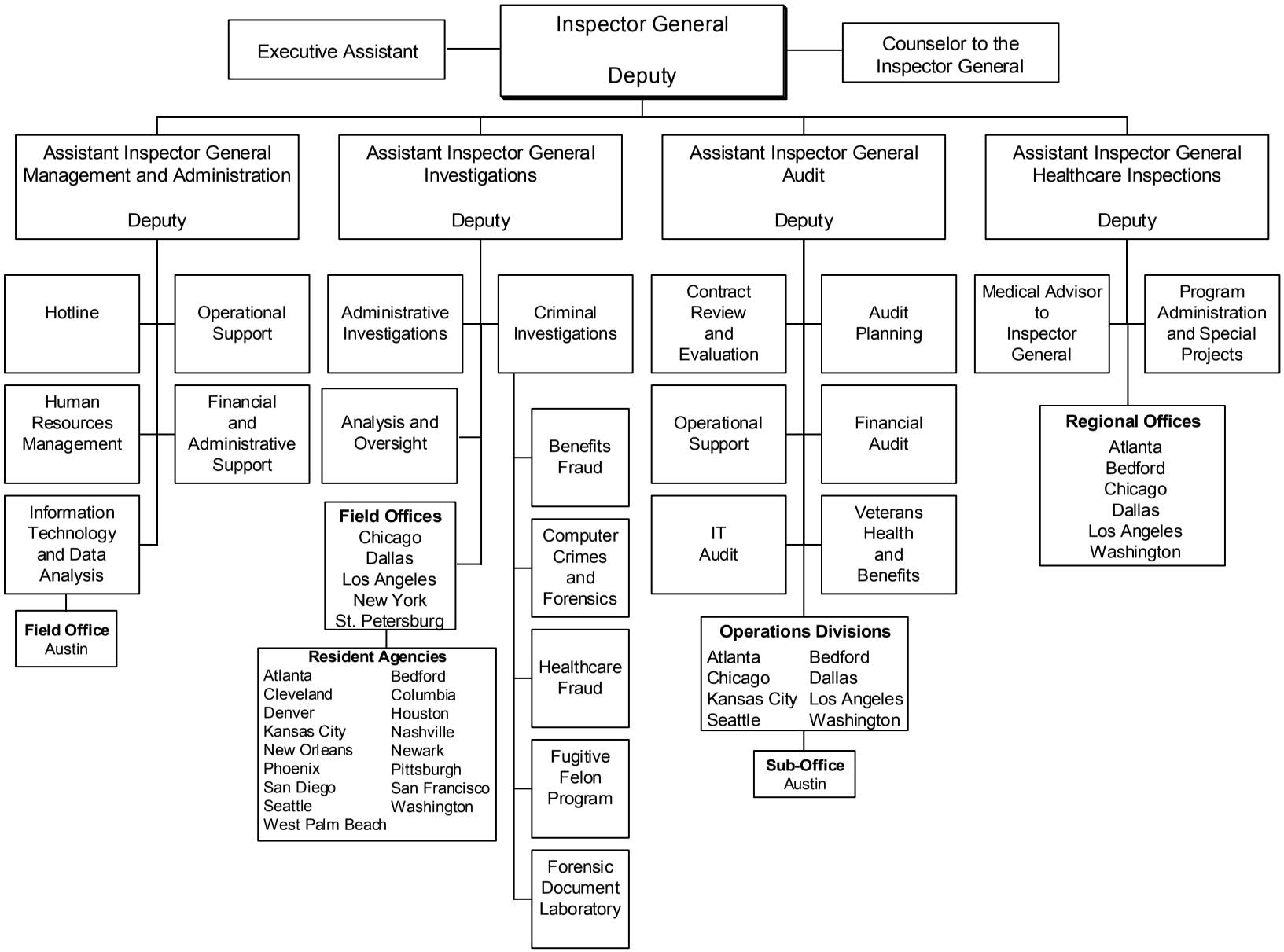
OIG Mission Statement

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

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

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

Department of Veterans Affairs
Office of Inspector General



COMBINED ASSESSMENT PROGRAM

Reports Issued

During the period October 1, 2003, through March 31, 2004, we issued 23 CAP reports. Of the 23 CAP reports, we reported on 16 VA health care systems, VAMCs, and a rehabilitation center; 4 VAROs; and 2 VA medical and regional office centers (VAMROCs). At one VAMROC, we issued two reports. We also issued three CAP summary reports during this period.

Combined Assessment Program Overview - Medical

CAP reviews are part of the OIG's efforts to ensure that quality health care services are provided to our Nation's veterans. CAP reviews provide cyclical oversight of VAMC operations, focusing on the quality, efficiency, and effectiveness of services provided to veterans by combining the skills and abilities of representatives from the OIG Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA health care systems.

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

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

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

During this period, we issued 18 health care facility CAP reports. See Appendix A for the full title and date of the CAP reports issued this period. These 18 reports relate to the following VA medical facilities:

- VA Greater Los Angeles Healthcare System, California
- VAMC Grand Junction, Colorado
- Robert J. Dole VAMROC, Wichita, Kansas
- VAMC St. Cloud, Minnesota
- G.V. (Sonny) Montgomery VAMC, Jackson, Mississippi

- W.G. (Bill) Hefner VAMC, Salisbury, North Carolina
- VAMC Muskogee, Oklahoma
- VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon
- James E. Van Zandt VAMC, Altoona, Pennsylvania
- VAMC Coatesville, Pennsylvania
- VAMC Lebanon, Pennsylvania
- VAMC Wilkes-Barre, Pennsylvania
- VA Black Hills Health Care System, South Dakota
- VAMC Salem, Virginia
- Louis A. Johnson VAMC, Clarksburg, West Virginia
- VAMC Tomah, Wisconsin
- VAMROC Cheyenne, Wyoming
- VAMC Sheridan, Wyoming

"The staff and I perceive the OIG CAP review as an opportunity to learn from our own review and those reviews conducted at other facilities. I personally appreciate the demeanor of the OIG CAP review team. The team members required us to take a critical look at our programs but did so in a manner that was assistive and not punitive."

Director, VAMC Salem, VA

"Please express my appreciation to the auditors and inspectors who conducted the review. The Medical Center staff appreciate their professionalism and efforts to assist in improving hospital operations and controls."

Director, VAMC Sheridan, WY

Summary of Findings

Deficiencies identified during prior CAP reviews relating to management of veterans health care programs were discussed in two recently issued OIG summary reports - Summary Report of CAP Reviews at VHA Medical Facilities, October 2002 through September 2003; and Summary Report of CAP Reviews at VHA Medical Facilities, October 2003 through December 2003. During this reporting period, we identified similar problems at the 18 facilities.

Procurement

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

- Government purchase card controls were deficient at 5 of 9 facilities where we tested these controls. Policy and procedures governing the use of purchase cards, setting purchasing limits, and accounting for purchases were not followed.

- Contract award and administration deficiencies were identified at 12 of 18 facilities where we tested these issues. Service contract controls were deficient at 8 of 11 facilities where we tested these issues. We identified deficiencies at all three sites visited where we reviewed clinical service contracts and sharing agreements, and all three sites where we reviewed non-clinical service contracts. We also noted deficiencies at

2 of 8 facilities where we tested community nursing home contracts, and both sites where we tested non-contract procurements. Controls needed to be strengthened to ensure that: (i) acquisition and materiel management staff determine price reasonableness in noncompetitive contracts, (ii) contract provisions include procedures to help ensure contract compliance, and (iii) contracting officials monitor contract performance.

- Scarce medical specialist services contracts were reviewed at three sites visited. At 2 of 3 sites, a VA policy had not been implemented that required the chief of staff and each physician, clinician, or allied health supervisor or manager to sign an acknowledgement form stating that they have read and agree to abide by the guidance in a VA handbook pertaining to the conflict of interest aspects of contracting for services.

- Management of supply inventories was deficient at 11 of 14 sites where we tested these controls. Medical supply inventory management was deficient at 6 of 8 facilities where we tested these issues, and nonmedical inventory management was deficient at 7 of 8 facilities where we tested these issues. We found that nonmedical inventories were either not performed or inaccurate. Also, management of equipment inventories was deficient at 3 of 6 facilities. Overall, we found that inventory levels exceeded current requirements resulting in funds being tied up in excess inventories.

Information Technology

A wide range of automated information system vulnerabilities were identified that could lead to misuse or destruction of critical sensitive information. VA had established comprehensive information security policies, procedures, and guidelines; however, CAP reviews found that facility policy development, implementation, and compliance were inconsistent. In addition, there was a need to improve access controls, contingency planning, incident reporting, and security training.

We found inadequate management oversight contributed to inefficient practices, and to inadequate information security and physical security of assets. CAP findings complement the results of our FY 2003 Federal Information Security Management Act audit, which identified information security vulnerabilities that place the Department at risk of: (i) denial of service attacks on mission critical systems, (ii) disruption of mission critical systems, (iii) unauthorized access to and improper disclosure of data subject to Privacy Act protection and sensitive financial data, (iv) fraudulent payment of benefits, and (v) fraudulent receipt of health care benefits.

- Information technology (IT) security deficiencies were found at 16 of 18 VHA sites visited. We found that: (i) security plans were not prepared or not kept current and lacked key elements, (ii) access to VHA's Veterans Health Information Systems and Technology Architecture was not effectively monitored, and/or (iii) background investigations were not conducted on contract personnel working in sensitive areas.

Controlled Substances

- VA has established policies, procedures, and guidelines for accountability of controlled substances and other drugs. However, controlled substance inspection procedures were inadequate to ensure compliance with VHA policy and U.S.

Drug Enforcement Administration regulations at 15 of 18 facilities visited. 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. The lack of management oversight at facility and VISN levels contributed to inefficient practices and to weaknesses in drug accountability.

Medical Care Collections Fund

- VA has increased Medical Care Collection Fund collections. However, we found deficiencies at 6 of 12 facilities where we tested these issues. Facility management needs to strengthen billing procedures to avoid missed billing opportunities.

Pharmacy Security

- VA needs to improve physical security in pharmacy areas. We found physical security deficiencies in pharmacy areas at 2 of 12 facilities where we tested these issues.

VA Black Hills Health Care System
Hot Springs, SD

Part-Time Physician Time and Attendance

- VAMC managers did not have effective controls in place to ensure that part-time physicians were on duty when required by employment agreements at 2 of 10 facilities where we tested these controls. Physicians did not complete appropriate time and attendance records, and timecards were not posted based on the timekeepers' actual knowledge of physicians' attendance. Additionally, timekeepers did not receive annual refresher training, and desk audits were not conducted, as required by VA policy.

Financial Controls

- Controls over the agent cashier function needed improvement at 2 of 4 sites where we tested the controls. We identified instances where the agent cashier was not escorted when making trips to the credit union, unannounced audits were not conducted timely, cash advance funds were not evaluated for adequacy during unannounced audits, and security cameras were not operational.

- Personal funds of patients accounts needed improvement at 2 of 5 sites where we tested the controls. Inactive accounts were not reviewed timely to verify patient status resulting in funds of patients being retained by the facility and not being transferred to patients, guardians, or patients' next-of-kin.

Health Care Management

- Inspectors reviewed the patient transportation services programs in 14 VHA facilities during the CAP reviews. We accompanied patient transports and observed driver safety practices; interviewed managers; reviewed local policies, employee and volunteer driver training records,

and VA transportation contracts; assessed how patient transportation is integrated in the facility's emergency preparedness plan; and collected information about employee and volunteer driver accidents. We identified opportunities for VHA to further define guidelines for employees and volunteers who transport patients; to strengthen initial and follow-up screenings of drivers, to include physical examinations, driving record reviews, and verifications of current state drivers' licenses; to ensure appropriate and necessary training is offered for drivers; to ensure systems are established to monitor VA-contract and fee-basis driver competency; and to ensure vehicles contain equipment for drivers' and patients' safety and protection.

Community Residential Care Program

- We reviewed VHA's policies and practices related to the community residential care program at seven medical facilities. We found that VAMC employees did not always follow inspection policies and procedures. Fire safety officers at 4 of 7 facilities did not routinely conduct annual fire safety evaluations, and employees at 2 of 7 facilities did not always verify that identified deficiencies were corrected. We also found that clinicians at 3 of 7 facilities did not consistently conduct or document monthly follow-up visits. VHA clinicians at 4 of 7 facilities did not meet with VBA field examination supervisors annually to discuss cases involving incompetent patients with fiduciaries. We made several recommendations.

Survey Results

Outpatient Surveys

We surveyed 438 VA outpatients at 18 facilities to ascertain their satisfaction with the care. We interviewed patients in primary care, mental health, or specialty care clinics. We also surveyed outpatients who were in waiting areas of the various supportive services such as pharmacy, radiology, and laboratory.

- Overall, 92 percent of the outpatients rated the quality of care as good, very good, or excellent. Ninety-two percent of the respondents stated they would recommend medical care to eligible family members or friends, and 89 percent told us their treatment needs were being addressed to their satisfaction.

- Eighty-eight percent of the outpatients told us they felt involved in decisions about their care, 82 percent told us a health care provider discussed the results of tests and procedures with them, 95 percent told us their primary care provider discussed the reasons for medications with them, 89 percent were told the reasons for referrals to specialists, and 92 percent were told why diagnostic tests were ordered.

- While 81 percent of the outpatients stated they received counseling by the pharmacist when they received new prescriptions and 83 percent said they received their refills in the mail before they ran out of medications, only 59 percent told us they received their prescriptions from the outpatient pharmacy within 30 minutes.

- Only 69 percent of the outpatients told us they were generally able to schedule appointments with their primary care providers within 7 days of their request, and only 71 percent of the outpatients who were referred to a specialist told us that they were given appointments and were assessed by the specialist within 30 days of the referrals.

Inpatient Surveys

We completed 288 inpatient interviews in 18 VHA facilities during this period. We surveyed patients in the areas of medicine, surgery, intensive care, mental health, nursing home, domiciliary, and special emphasis programs.

- We discussed the results with local management officials before leaving the sites. Overall, 96 percent of patients would recommend VA medical care to eligible family members or friends and 95 percent of the inpatients interviewed rated the quality of care as good, very good, or excellent. Results of these findings were discussed with facility managers during site visits.

Physical Plant Environment

We inspected 222 areas at 18 facilities, including primary care and specialty outpatient clinics, inpatient wards, emergency rooms (ER), intensive care/coronary care units, nursing home care units, domiciliary units, psychiatry units, surgery, and rehabilitation areas.

- Overall, we found 80 percent of the areas we inspected were generally clean and had good sanitation. While minor uncleanliness could be identified in all facilities, management was responsive and took immediate corrective actions for equipment in the hallways (15 percent), nourishment kitchen maintenance (10 percent), and repairs needed (7 percent). Among safety deficiencies, inspectors found 9 percent of all chemicals and cleaning supplies were not stored properly.

- VA has established certain guidelines to prevent suicide within inpatient mental health areas. We found showerheads were not always constructed in order to prevent suicide (10 percent), grab bars were not properly constructed (10 percent), and sprinkler heads were not constructed to break away from body weight (7 percent).

VA Medical and Regional Office Center
Cheyenne, WY

Employee Surveys

Employee feedback was obtained from responses to a web-based survey we implemented at 18 CAP reviews. All employees of each facility were notified by e-mail about the survey and were provided with the web address. We received 2,362 responses. Since we began performing CAP reviews, we have systematically elicited employees' perceptions on a wide range of issues. We believe that the resulting data can provide an independent, objective indicator of employee satisfaction for facility management to use in decision-making. VHA aspires to be the employer of choice. We provided facility management with survey results obtained during CAP reviews.

- Eighty-one percent of the employees who responded felt that quality patient care was the first priority at their medical center. Eighty-five

percent of the respondents believed the quality of care provided to patients at their respective facilities was either good or excellent. Eight-five percent of the employees who responded felt their medical center was clean, and 72 percent of them asserted they would recommend their facility to an eligible family member or friend.

- Eighty-seven percent of the respondents believed they received proper orientation, education, and training to do their jobs. In addition, 61 percent of these employees felt management provided them opportunities to fulfill their continuing education needs or requirements. Seventy-six percent of the employees who responded asserted that adequate supplies were available for them to do their jobs.

We noted the following deficiencies that were common to most facilities:

- Fifty percent of the responding employees believed they had not been offered opportunities for career advancement.

- Thirty-three percent of respondents asserted work orders for needed repairs were not addressed promptly at their facilities.

- Only 41 percent of responding employees felt staffing levels were usually sufficient to provide safe patient care.

Combined Assessment Program Overview - Benefits

During this period, we issued six CAP reports on the delivery of benefits. See Appendix A for the full title and date of the CAP reports issued this period. These six reports relate to the following benefit facilities:

- VARO San Diego, California
- Robert J. Dole VAMROC, Wichita, Kansas
- VARO Buffalo, New York
- VARO Columbia, South Carolina
- VARO Houston, Texas
- VAMROC Cheyenne, Wyoming

Summary of Findings

Deficiencies identified during prior CAP reviews in the management of veterans benefits programs were discussed in a recently issued OIG summary report - Summary Report of CAP Reviews at VBA Regional Offices October 2002 through September 2003. During this reporting period, we identified similar problems at the six regional offices. The following areas required the attention of VBA management.

Information Technology

The CAP review coverage of VBA facilities in FY 2004 identified a wide range of vulnerabilities in VBA systems similar to those we identified during VHA CAP reviews. The deficiencies could lead to misuse or loss of sensitive automated information and data. The CAP review findings show a need to improve access controls, contingency planning, risk assessments, and security training. Inadequate management oversight contributed to inadequate information security and physical security of assets.

- IT security was deficient at 4 of 6 offices reviewed. Risk assessments needed to be conducted, and some contingency plans required revision and testing. Physical security of IT equipment at one site needed prompt attention.

VA Regional Office
Houston, TX

Compensation and Pension Claims Processing

- Timeliness of compensation and pension claims processing needed improvement at all five offices where we tested the processing. The claims had avoidable processing delays and/or procedural errors that affected workload and timeliness measures. Managers need to consult with medical center staff to improve compliance with requirements for notification when veterans are hospitalized for extended periods and provide refresher claims processing training for veteran service center staff.

- Other deficiencies found during our visits included inaccurate actions on system error messages, inaccurate entry of data, and improper reduction by veteran service center personnel of pension benefits of veterans hospitalized for extended periods at Government expense.

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 5 of 6 sites where we tested these issues. Management needs to process claims for vocational rehabilitation benefits in a timely manner, enter accurate data, and monitor claims status. When appropriate, action is needed to be taken to place veterans who are not pursuing their approved training programs in discontinued or rehabilitated program status.

- Government purchase card program deficiencies existed at 2 of 5 sites where we tested the program controls. Reconciliations and certifications were not performed timely, single purchase limits were not enforced, and purchase card duties were not separated. Management needs to reiterate the need to record the dates of monthly purchase card reconciliations and certifications, ensure micro-purchases do not exceed the $2,500 limit, and ensure separation of duties or explain why the facility can not meet the requirement and document the reasoning for their modified policy on separation of duties.

- We found that improvements were needed in fiduciary accounting and field examination controls and procedures at 4 of 5 offices where we tested these issues. Fiduciary accountings were not always submitted timely or accurately. Management needs to improve the oversight of incompetent beneficiaries' funds by ensuring accountings and field examinations were conducted timely and appropriate corrective action was taken.

Interim Report Issued - VAMC Bay Pines, Florida

• Allegations Questioning Clinical and Administrative Activities

We received requests from the Secretary of Veterans Affairs and Congressional members to review allegations questioning the adequacy of clinical and administrative activities at VAMC Bay Pines, Florida. On March 19, 2004, we issued

an interim report to disclose the progress of patient care and administrative issues at VAMC Bay Pines. A final report will be issued when we have completed our review of all the allegations.

VA Medical Center
Bay Pines, FL

Our review found that VAMC managers cancelled surgeries because critical surgical supplies and instruments were not consistently available or properly sterilized by supply processing and distribution. Other deficiencies identified included improper sterilization procedures, inadequate inventory practices, and poorly trained staff. Our review also showed that VA CoreFLS project managers still have significant work to do to implement the CoreFLS system. CoreFLS issues on data conversion, testing, training, interfacing with other VA systems, information security, and contracting processes need management attention.

This is an interim disclosure report and, as such, there are no recommendations. We will include them in the final report. (*Interim Report - Patient Care and Administrative Issues at VAMC Bay Pines, FL, 04-01371-108, 3/19/04*)

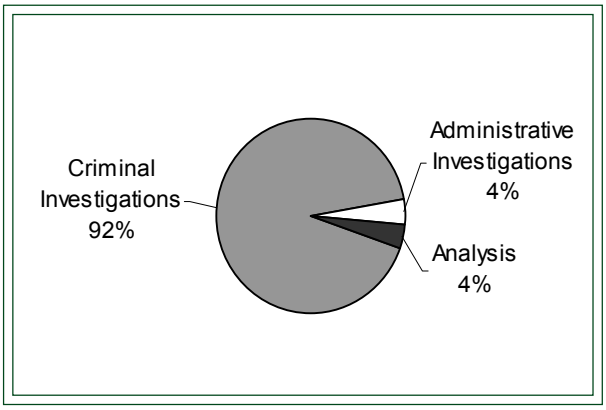
OFFICE OF INVESTIGATIONS

Mission Statement

Conduct investigations of criminal activities and administrative matters relating to the programs and operations of VA in an independent and objective manner and seek prosecution, administrative action, and/or monetary recoveries in promoting integrity, efficiency, and accountability within the Department.

Resources

Overall, the Office of Investigations has 136 FTE allocated to its three divisions: Criminal Investigations Division, Administrative Investigations Division, and the Analysis and Oversight Division. The following chart shows the allocation of resources.

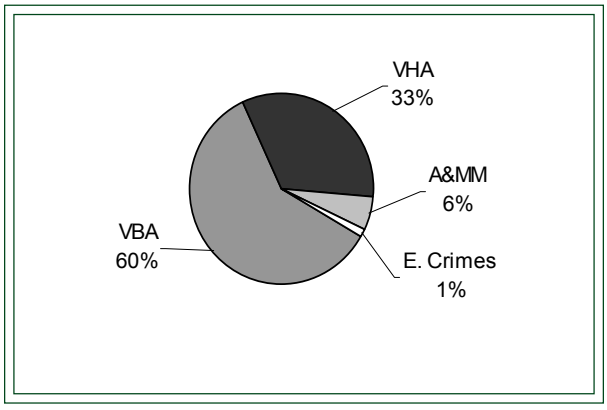


I. CRIMINAL INVESTIGATIONS DIVISION

This 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 both the questioned document forensic laboratory and the computer crimes forensic laboratory.

Resources

The Criminal Investigations Division has 121 FTE allocated for its headquarters and 22 field locations. These individuals are deployed in the following VA program areas.



Overall Performance

Output

- 502 investigations were concluded during the reporting period.

Outcome

- Arrests - 286
- Indictments - 161
- Convictions - 158
- Pretrial Diversions - 11
- Fugitive Felon Apprehensions - 149*
- Administrative Sanctions - 192 (criminal investigations)
- Monetary benefits - $18.2 million ($7.8 million - fines, penalties, restitutions, and civil judgments; $5.9 million - efficiencies/funds put to better use; and $4.5 million - recoveries)

* This includes the total fugitive felon apprehensions made by VA OIG and other law enforcement agencies during this reporting period.

Customer Satisfaction

- Customer satisfaction during this reporting period was 4.9 on a scale of 5.0.

Veterans Health Administration

The Criminal Investigations Division investigates those instances of criminal activity against VHA that have the greatest impact and deterrent value, including crimes such as patient abuse, theft of Government property, drug diversion, bribery/kickback activities by employees and contractors, false billings, and inferior products. Working closely with VA police, the Division 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 VAMCs. During this semiannual period, OIG special agents have participated with or provided support to VA police, in the arrest of 56 individuals who committed crimes on VHA properties.

Homicide, Manslaughter, and Fraud

- One of our more significant investigations involved a former chief research coordinator at the Veterans Affairs Medical Center (VAMC) Albany, NY, who has been charged in a 48-count felony indictment for criminally negligent homicide, manslaughter, and fraud for falsifying veterans' medical records in order to enroll them in cancer research studies sponsored by private pharmaceutical companies. The indictment

Times Union
Albany, NY
Thursday, October 30, 2003

Ex-VA staffer indicted in death

Albany Former Stratton researcher faces 48 counts alleging that an Air Force vet died because of his drug study scheme

followed an investigation that revealed the researcher's alterations, forgeries, and false statements pertaining to the official records led to the 2001 death of a veteran who had sought treatment for gastric cancer. The researcher allegedly falsified blood tests, switched the records of potential research patients with other patients, and doctored lab reports to camouflage the fraud. The investigation also revealed that the researcher was dismissed from medical school for falsifying transcripts in 1984, was convicted of mail fraud for falsifying information on a medical license application in 1992, and had lied on his federal employment application regarding his undergraduate performance and mail fraud conviction. The investigation is ongoing and could result in charges being filed against additional subjects.

Theft/Diversion of Pharmaceuticals

- A former VA pharmacy technician was sentenced to 24 months' incarceration, 36 months' supervised probation, and ordered to make restitution of $54,295. Additionally, the individual was ordered to forfeit $600,000, which represented the subject's proceeds from the criminal scheme, to the U.S. Treasury. A VA OIG investigation disclosed that the former pharmacy technician and a former VA purchasing agent diverted approximately 600,000 tablets of Hydrocodone and Alprazolam from a VA outpatient clinic from 2001 to 2003.

- After pleading guilty to theft of pharmaceutical drugs, a VA nurse was sentenced to 36 months' probation. In accordance with a plea agreement, the nurse was also required to voluntarily surrender her nursing license for the period of probation and participate in a drug rehabilitation program. A joint VA OIG/VA police investigation disclosed that the nurse, a 13-year VAMC employee, diverted in excess of 1,000 Hydrocodone tabs for her own use during a 1-year period. The drugs had been prescribed to local veterans seeking treatment. Complaints from veterans about missing prescriptions prompted the investigation.

Improper Medical Treatment

- A VA OIG investigation resulted in the arrest of a nurse working in a surgical intensive care unit at a VAMC who was dispensing a controlled substance outside the parameters of the law. The investigation disclosed that a significant shortage of morphine was detected during a routine inventory. Additional discrepancies were detected in the nurse's narcotics log. During interview, the nurse admitted that he illegally gave medication to ensure patients remained pain free, to regulate blood pressure, and to increase sedation. The nurse was released on bond and is awaiting his next court appearance. He was placed on administrative leave with pay.

Attempted Murder

- The VA OIG was requested to assist in the investigation of a VAMC employee who was arrested and charged with attempting to kill an employee of the United States and other felony firearms-related offenses. The investigation disclosed that the employee arrived at the hospital armed with a 12-gauge shotgun, 7 mm rifle, .22 caliber rifle, and a .380 caliber pistol, entered the human resources service, and fired the 12-gauge shotgun directly into a desk under which an employee was taking cover. He then fired the shotgun two more times through the closed office door of the assistant chief of human resources service. The employee then left the building, reloaded the shotgun, and went to an

area where he had left a loaded 7 mm rifle. At this point, VA police arrived on the scene in a marked patrol car. The employee fired two additional times with the shotgun striking the windshield of the patrol car. VA police returned fire and subsequently took the gunman into custody uninjured. A Federal criminal complaint was filed and the case is pending further judicial action.

Identity Theft

- An individual pled guilty to knowingly possessing false identification documents with the intent to defraud the United States. A VA OIG investigation disclosed that the individual, a non-veteran, went to a VAMC for a scheduled appointment and was found to be in possession of a Social Security card and a veterans universal access identification card bearing the name and Social Security number of a legitimate veteran. Investigation showed that since the mid-1990's, the individual had used the veteran's identity to obtain medical services at four VAMCs around the country. The total VA loss was approximately $21,000.

Health Care Fraud

- A veteran and her former caregiver were indicted and charged with wire fraud. The charges concluded an 18-month VA OIG investigation that disclosed the veteran, who claimed to suffer from Post Traumatic Stress Disorder (PTSD), and the caregiver created a fictitious company that allegedly treated the veteran for her condition. The veteran had previously convinced VA officials that she had flashbacks and needed a full-time caregiver. The veteran and caregiver submitted fictitious time sheets of non-existent employees to VA. Consequently, they received wire transfers reflecting claims paid by VA in the scheme resulting in a loss of $31,620. Each subject has been indicted and is pending further judicial action.

Sexual Assault

- A former VAMC nursing assistant was arrested by VA OIG agents and local police and charged with four counts of felony sexual battery. The arrest was based on a VA OIG investigation of reports by two terminally ill female VAMC patients that the nursing assistant sexually assaulted them. The victims provided a sworn statement of their accounts of the sexual batteries. Both victims have since died from their illnesses. The subject provided a full confession during his interview. Subsequently, two additional victims, aged 64 and 67, were identified. One of these victims was terminally ill at the time of the incident and is now deceased. The other victim has advanced stages of Parkinson's disease. Pursuant to his arrest, the nursing assistant was re-interviewed and denied indecently assaulting the third terminally ill patient; however, he admitted to indecently assaulting the patient with Parkinson's disease.

Procurement Fraud

- A VAMC plumbing supervisor pled guilty to criminal charges relating to kickbacks and conspiracy. Two contractors involved in the scheme have already signed plea agreements in which they agreed to plead guilty to conspiracy charges. The indictment and plea agreements followed a VA OIG investigation that disclosed the VAMC employee and contractors engaged in a scheme to inflate and falsify purchase orders for emergency and routine plumbing repairs at the VAMC. Over a 3-year period, the contractors overcharged the VAMC more than

$80,000. This amount represents the money the contractors paid the VAMC employee in order to obtain work at the VAMC.

- The chief executive of a construction company was found guilty following a 2-week trial on charges of money laundering, wire fraud, mail fraud, and making false statements to both Government and private entities, including VA and the Small Business Administration. The investigation, with VA OIG audit assistance, disclosed a conspiracy with other individuals, two of whom have already been convicted, to defraud the various entities by filing false statements. During the period of the thefts, the executive's company was engaged in VA construction contracts at two VAMCs totaling over $2.2 million. As a result of this conviction, the individual faces 72 months' imprisonment at the time of sentencing.

- A VA contractor pled guilty to charges of conspiracy to bribe a public official. A VA OIG investigation disclosed the contractor was awarded contracts in return for paying a Government employee between $250 and $600 in cash for each awarded contract. The scheme was facilitated by a former VA employee who released sealed bid information to the contractor that allowed the contractor to submit lower bids and receive Government repair contracts. The VA employee also created fictitious repair jobs for which the contractor would submit invoices. The subsequent payment would be split between the co-conspirators. The scheme caused VA to lose over $355,000. The employee was previously arrested and is awaiting further judicial action

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Bank Fraud

- After pleading guilty to bank fraud, a former credit union employee was sentenced to 18 months' probation, with the first 6 months to be served in home confinement, and ordered to pay $31,222 in restitution . The sentencing followed a VA OIG investigation that disclosed two tellers, one of which was previously sentenced, fraudulently withdrew a total of $68,900 in funds from a VAMC Federal credit union. The credit union manager detected the theft and requested an audit of the missing funds. The two tellers quit their positions immediately prior to the audit. A review of the tellers' electronic password histories revealed they were used to access the missing funds. Both individuals admitted in sworn statements to logging fabricated transactions in order to conceal their theft of funds.

Veterans Benefits Administration

VBA provides wide-reaching benefits to veterans and their dependents, including compensation and pension 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 disabilities, third parties steal pension payments issued after the unreported death of the veteran, individuals provide false information so that veterans qualify for VA guaranteed property loans, equity skimmers dupe veterans out their homes, and educational benefits are obtained under false representations. The Office of Investigations spends considerable resources in investigating and arresting those who defraud operations of VBA.

Death Match Project

- The Office of Investigations is conducting an ongoing proactive project in coordination with VA OIG Information Technology and Data Analysis Division. The match is being conducted to identify individuals who may be defrauding VA by receiving VA benefits intended for veterans whose deaths have not been reported to VA. 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 in excess of 8,700 possible investigative leads. Over 5,000 leads have been reviewed, resulting in the development of 713 criminal and administrative cases. Investigations have resulted in the actual recovery of $10.5 million, with an additional $7.5 million in anticipated recoveries. The 5-year projected cost avoidance to VA is estimated at $24.8 million. To date, there have been 94 arrests in these cases with several additional cases awaiting judicial actions.

Benefits Fraud

- An information was filed charging the son and daughter-in-law of a deceased veteran with theft of Government funds. The information was based on an investigation that revealed that the son had a joint bank account with his stepmother who had been receiving Dependency and Indemnity Compensation benefit payments as a result of his father's death. The son failed to report the January 1986 death of his stepmother to VA. At various times during the next 14 years, the defendants withdrew the benefit payments and used the money for personal expenses. Total VA loss is $154,312.

- An individual pled guilty to theft and mail fraud charges and was sentenced to 30 months' imprisonment, 2 years' supervised release, and ordered to pay $130,820 in restitution to VA. The sentence was based on a VA OIG investigation that disclosed the individual had assumed the identity of several different people in an effort to gain employment and VA benefits. Investigation disclosed the individual fraudulently received VA pension checks and medical treatment from eight different VAMCs.

- An individual was sentenced to 4 months' incarceration, 4 months' home confinement, 3 years' supervised release, and ordered to make restitution of $140,000. The sentencing resulted from the individual's conviction for theft of VA compensation benefits. The VA OIG investigation disclosed the individual, who held joint ownership of a bank account with a legitimate VA compensation recipient, failed to notify VA of the beneficiary's death and continued to access and withdraw VA benefits payments deposited into the bank account.

- An individual was indicted for theft of Government funds, following a joint VA OIG and SSA OIG investigation. The investigation disclosed the individual fraudulently received and negotiated her estranged husband's VA and Social Security disability compensation benefits. She wrongfully received $156,957 from VA and $42,108 from SSA. A trial date is pending.

- A veteran was sentenced to 37 months' imprisonment and ordered to pay restitution of $384,934 to VA after pleading guilty to a two-count indictment charging him with making false claims against the United States. A VA OIG investigation disclosed that the individual fraudulently collected compensation benefits since 1991, claiming he could not walk without the use of braces, crutches or a wheelchair. Because of the nature of the veteran's disability, he also

received special monthly compensation, compensation for special adaptive housing, and assistance with purchasing an automobile. Investigation disclosed that he could walk without the aid of assisting devices.

Port St. Lucie News
Port St. Lucie, FL
Tuesday, March 16, 2004

VA fraud case nets 3 years in prison

Navy veteran pleaded guilty in November to defrauding the U.S. Department of Veterans Affairs by faking the need for a wheelchair.

By Melissa E. Holsman
staff writer

From faking the need for a wheelchair to picking up a 20-pound box of pretzels, Richard L. Fried fraudulently collected about $385,000 in veteran's disability benefits — and on Monday he paid.

An angry U.S. District Judge K. Michael Moore accused Fried of a "snow job" on the veterans system and sentenced him to more than three years in prison.

"I think they

Fried

- A veteran was sentenced to 6 months' imprisonment and 60 months' probation, and ordered to pay $67,893 restitution stemming from a previous theft conviction. A VA OIG investigation determined the veteran had been fraudulently receiving pension benefits since 1994 while working full-time and improperly reporting no income to VA. The veteran confessed he falsely reported zero income to VA while he was employed because he was afraid of losing his VA pension.

- A veteran pled guilty to a charge of criminal conduct for making false statements under oath relative to his VA PTSD claim. The veteran was immediately sentenced to 30 days' home confinement and 36 months' probation. A joint VA OIG and FBI investigation disclosed that for the past 17 years, the veteran defrauded VA by claiming to have PTSD due to his combat experience in Vietnam when, in fact, the veteran saw no combat in Vietnam. The VA's loss is $168,000.

- A veteran and his wife were indicted and charged with conspiracy to defraud VA through interstate wire communications, mail fraud, and making false statements. A joint VA OIG and SSA OIG investigation revealed the veteran, who is 100 percent service-connected, and his wife conspired to increase the veteran's compensation benefits by providing false information in order to receive payment for aid and attendance that was allegedly provided by his wife. Also, in statements to the SSA to increase her Social Security disability benefit payments, the wife falsely claimed she could not walk and was in need of aid and attendance for services provided by the veteran. The veteran admitted he and his wife had conspired to lie to VA so he could receive a higher amount of compensation payments. In addition, he admitted he could walk, at which time he stood up and walked out of the VAMC. Based upon the alleged fraud, VA paid the pair approximately $150,000 in benefits to which they were not entitled.

- A veteran was indicted and charged with wire fraud and making false statements. The indictment followed a joint VA OIG and SSA OIG investigation that disclosed the veteran, to increase her compensation payments above her entitlement, falsely informed VA and SSA that she was unable to walk and was confined to a wheelchair. The total loss to the Government is $200,000.

- A veteran was indicted on charges of theft of Government funds and wire fraud. The indictment resulted from a VA OIG investigation that disclosed the veteran fraudulently claimed a service-connected disability for blindness when, in fact, his visual acuity appeared to be much better than he claimed. The veteran's actions caused VA to pay entitlements, of which $670,000 is in question.

Fiduciary Fraud

- An individual was arrested following indictment on charges of misappropriation of funds by a fiduciary. The VA OIG investigation disclosed the individual, a VA-appointed guardian for several incompetent veterans, embezzled approximately $85,000 of the veterans' funds. The individual used the funds for personal expenses, including a down payment on a home.

- Two attorneys were indicted on charges of theft of Government property, mail fraud, and false statements. The indictment followed a VA OIG investigation that disclosed the attorneys, who were appointed as fiduciaries for incompetent veterans, stole money from the veterans whose financial affairs they were entrusted to manage. One attorney stole over $38,000 and the other over $100,000.

Bribery

- A former executive vice president of a technical college, pled guilty to conspiracy and bribery of public officials and witnesses. The VA OIG investigation disclosed the subject offered cash and gifts to a VA vocational rehabilitation counselor for referring students to his college. The subject, a veteran himself, also paid cash to the counselor, who was acting at the direction of the OIG, in return for being enrolled in VA's vocational rehabilitation program and for the purchase of a laptop computer. The subject, already on probation for a 1999 conviction for income tax evasion and witness tampering, was sentenced to 19 months' imprisonment, 3 years' probation, and fined $10,000. Prior to his arrest, this defendant unwittingly introduced the president of the technical college to a special agent of the OIG who was acting in an undercover capacity by posing as a VA vocational rehabilitation counselor. The president offered a bribe to the special agent and was later arrested. He subsequently pled guilty to a single count of bribery and is awaiting sentencing.

- A former VA contractor was sentenced to 24 months' imprisonment and 36 months' supervised release, and ordered to pay $90,000 in restitution to VA. A joint investigation by the FBI and VA OIG disclosed that over a 3-year period, the VA contracting official awarded the contractor repair contracts valued at $355,462 in return for bribes.

Loan Guaranty Fraud

- Two individuals were sentenced to a total of 51 months' imprisonment, 72 months' probation, and $90,000 in fines, and ordered to make restitution of $1,366,279. Their sentencing followed guilty pleas to charges of bankruptcy

fraud, equity skimming, conspiracy, false use of a Social Security number, and making a false statement in a bankruptcy. The charges stemmed from a joint FBI, VA OIG, SSA OIG, Department of Housing and Urban Development (HUD) OIG investigation that disclosed the subjects' involvement in a 10-year equity-skimming scheme, in which they filed fraudulent bankruptcies to forestall foreclosure on hundreds of VA-guaranteed, HUD-insured, and conventionally insured properties.

- A civil settlement agreement was reached regarding a *qui tam* lawsuit that was filed against a law firm under the False Claims Act. The lawsuit alleged the law firm made numerous false claims involving mortgage loan guarantees granted by VA and HUD by falsely claiming reimbursement for fees they did not incur while handling a large number of VA and FHA foreclosure sales. The allegations were substantiated and the firm agreed to pay $676,852 to settle the case. Half of the settlement will go to VA and HUD to cover losses. Another quarter of the settlement will go to the Department of Justice, and the remaining quarter will go to the *qui tam* relator.

Fugitive Felon Program

The Office of Investigations Fugitive Felon Program identifies VA benefits recipients who are fugitives from justice. The program evolved after Congress enacted Public Law 107-103, Veterans Education and Expansion Act of 2001, prohibiting veterans who are fugitive felons, or their dependents, from receiving specified benefits. The program consists of conducting matches between fugitive felon files of law enforcement organizations and more than 11 million records contained in VA benefit system files. Once a veteran is identified as a fugitive, information on the individual is provided to the law enforcement organization responsible for serving the warrant to assist in the apprehension. Information is then provided to the Department so benefits may be suspended and to initiate recovery action for overpayments.

To date, Memoranda of Understanding/ Agreements have been completed with the U.S. Marshals Service and the National Crime Information Center, as well as with the States of California, New York, Tennessee, and Washington. Additional agreements are in the process of being negotiated with other states. The program has led to additional cooperative efforts between the VA OIG, VBA, VHA, and the VA Police in an attempt to implement this new initiative.

Investigative leads provided to law enforcement agencies since the inception of the program have led to the arrest of fugitives wanted for murder, manslaughter, sexual assault, robbery, drug offenses, and other serious felonies. The apprehension of these subjects has made VA facilities safer for our veterans, employees, and the general public.

The following are examples of fugitive felon apprehension cases:

- A local sheriff's department requested the assistance of the VA OIG in locating a veteran who was wanted on charges of sexually assaulting a child. A VA OIG agent developed potential

The following table identifies the statistics relating to the Fugitive Felon Program during this reporting period, as well as from the inception of the program.

Fugitive Felon Program	This Reporting Period	Total
Felony Warrants Received from Participating Agencies	1.2M	1.8M
Matched Records	14,953	27,661
Referred to Law Enforcement Agency That Holds the Warrant	4,341	10,354
Arrests Made by Law Enforcement Agency That Holds the Warrant	50	129
Arrests Made by OIG	99	195
Referrals to VBA for Benefits Suspension	4,236	6,530
Estimated Identified Overpayments	$32M	$46.8M
Estimated Cost Avoidance	$55.8M	$100M

M = Million

location information from VA records and together with local sheriff deputies apprehended the subject.

- A warrant was issued for an individual as a result of a Drug Enforcement Administration case. Investigative leads developed by the VA OIG resulted in the subject's arrest at a VAMC by VA OIG agents and deputy U.S. Marshals.

- A VA human resources and labor relations specialist was arrested by VA OIG agents and officers of a local sheriff's department based on an arrest warrant issued after the employee was indicted on charges of felony assault on a police officer. The employee was arrested without incident at a VAMC.

OIG Questioned Document Forensic Laboratory

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

There were a total of 20 completed laboratory cases during this semiannual period.

Laboratory Cases for the Period	
Requester	Cases Completed
OIG Office of Investigations	9
VA Top Management	3
VA Regional Offices	8
TOTAL	**20**

The following are examples of completed laboratory reports.

- The VA OIG and SSA OIG conducted a joint investigation that disclosed a veteran's brother used the identity of the veteran to obtain service-connected compensation benefits and medical services. The VA OIG laboratory identified the brother as the author of numerous fraudulent documents on which the VA relied to grant a 100 percent service-connected disability rating for PTSD. As a result of the subject's deception, VA lost $300,000 and SSA lost an additional $40,000 in benefit payments.

- The Philadelphia VARO and Insurance Center requested laboratory examinations of three critical documents that would be the basis of awarding VA life insurance funds. Laboratory examinations determined two of the documents were fraudulently created and identified the individual who had authored handwritten entries on one of the documents. The laboratory report was used by VA insurance officials in the decision to disperse the VA life insurance funds of $40,615 to the correct beneficiary.

- The Manila VARO requested laboratory examination of medical records which the widow of the veteran used as justification for a service-connected death benefit award. Laboratory examinations of type font design typewriter entries, pre-printed letter head defects, copy toner, and signature examinations, determined 19 medical records were fraudulently created. The laboratory report was used as basis for denial of the widow's application for VA benefits.

OIG Computer Crimes Forensic Laboratory

The Office of Investigation operates a computer crimes forensic laboratory in Washington, DC. The laboratory offers forensic support in the examination of computers, removable storage media, personal digital assistant, and other digital storage devices. The laboratory provides support to VA OIG special agents nationwide in the investigations of fraud, misuse of Government equipment, identity theft, and child pornography.

There were a total of 12 completed laboratory cases during this semiannual period.

Laboratory Cases for the Period	
Theft	3
Child/Adult Pornography	5
Record Alteration	1
Fraud	2
Misuse of Government Systems	1

The following are notable cases:

- A VA employee was arrested on suspicion of possession of child pornography. With the

assistance of the investigating agent and preliminary examinations conducted at the OIG field office, the laboratory personnel provided a written report and expert testimony in the ensuing trial. The testimony lasted for 3 days and involved extensive use of a portable forensic examination station in the courtroom that was constructed by the laboratory personnel. The VA employee was found guilty on two counts of possession of child pornography. This case was the first jury conviction for the VA OIG in this field.

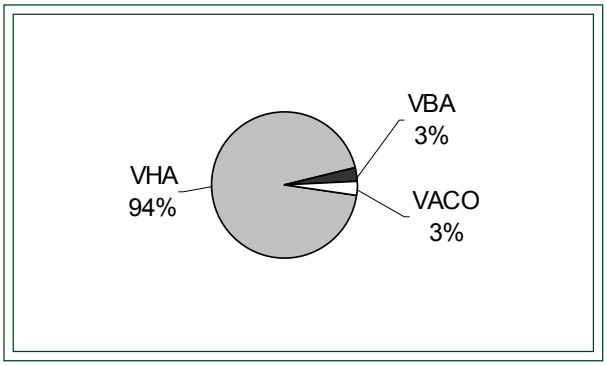
- A VA employee was suspected of creating false invoices on behalf of veterans. An examination of his laptop computer revealed several deleted files and fragments of files that could be reconstructed to recreate the invoices. A report was issued along with the recreated invoices. The suspect was arrested and later pled guilty.

II. ADMINISTRATIVE INVESTIGATIONS DIVISION

This Division is generally responsible for investigating allegations against senior VA officials and other high profile matters of interest to Congress and the Department.

Resources

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



Overall Performance

Output

- The Division closed 12 cases and issued 7 reports and 2 advisory memoranda.

Outcome

- VA managers agreed to take 28 administrative sanctions, including personnel actions against 9 officials, and corrective actions in 19 instances to improve operations and activities. The corrective actions included taking several steps to withdraw research funds from a private nonprofit corporation not authorized to administer those funds on behalf of VA; issuing bills of collection to recoup Government funds spent for employees' personal benefit, including meals and entertainment, and for improper travel claims; directing a physician to return cash received as gifts from pharmaceutical companies; correcting appointments improperly made without competition; and establishing policies prohibiting the use of VA-affiliated nonprofit research corporation funds to purchase food and entertainment.

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

Veterans Health Administration

Solicitation of Gifts and Other Ethics Violations

- An administrative investigation substantiated a VAMC physician violated ethical conduct standards, primarily regarding his relationship with pharmaceutical and medical equipment companies. The physician solicited gifts of cash from pharmaceutical companies, which are prohibited sources, to offset the cost of a cardiology symposium initially paid for from personal and private research foundation funds. The physician used his official position for personal gain when he sent the solicitation letters on VA letterhead containing his official VA title, thus implying that VA sanctioned his solicitation, and asked that the cash be deposited in the private research foundation; gave the appearance that he lacked impartiality in performing his official duties when he allowed three companies doing business with VA, including two he had solicited, to attend or speak at the symposium; gave a gift to two superiors when he paid for their dinner and entertainment at a party he hosted; and did not fully cooperate with our official investigation. Subsequent to our draft report, VHA officials did not renew the physician's temporary appointment. The investigation also disclosed the medical center improperly allowed pharmaceutical companies to provide meals on a routine basis to clinical staff and residents. In response to a recommendation, VHA officials discussed and distributed policy explaining this practice is prohibited.

Misuse of Nonprofit Research Corporation Funds

- An administrative investigation substantiated that officials from a VA nonprofit research corporation improperly spent corporation funds on meals and entertainment. Employees who took part in these activities created the appearance they misused their positions for personal gain by benefiting from free meals. The affiliated VAMC's director, as the highest-ranking VA official on the corporation's board of directors, did not ensure the corporation furthered the interests of the Department, as required. VHA officials took numerous actions to educate both VA employees throughout the Network, and the corporation's board of directors and executive director, regarding the appropriate use of VA nonprofit research corporation funds.

Contract Irregularities and Questionable Expenditures

- An administrative investigation substantiated that a VHA senior official repeatedly requested that contracting officials procure services from specifically named vendors whom he knew personally, or with whom he had previously worked, even after the official was advised about what conditions must be satisfied before a sole-source procurement can be properly awarded. In requesting the procurements, the senior official made statements about the uniqueness and urgency of his office's requirements, and the skills of the particular vendors he requested, that were factually unsupported or misleading. The investigation further substantiated the senior official allowed contractors to perform services that were not authorized by a purchase order, and misrepresented to the contracting office the nature of the services being billed on an invoice. Finally,

the investigation substantiated the senior official wasted funds while planning and convening two staff retreats, and misled his supervisor about their costs. In response to our recommendations, VHA agreed to take appropriate administrative action against the senior official, and to issue him a bill of collection to recoup the funds he allowed to be spent on entertainment during one staff retreat.

Use of Government Funds, Travel, Personnel, Impartiality, and Management Issues

- An administrative investigation substantiated a senior official in VHA Central Office, and certain members of that official's staff, were responsible for improperly spending nearly $1.7 million provided to VA by pharmaceutical companies, and maintained and administered by a private nonprofit corporation, for VA's use in conducting specific research studies. The money was used for purposes unrelated to the projects specified, including some personal items. The senior official's predecessors acted similarly in misspending a lesser amount of these funds. The improper purchases should have been paid for either from appropriated funds or personally by members of the staff.

Among the other findings, the administrative investigation substantiated the senior official.

- Traveled unnecessarily, took circuitous routes, claimed lodging expenses above the allowable limits, used expensive ground transportation, and claimed other improper expenses totaling $9,737.
- Gave improper preference to four individuals the official wanted hired or promoted.
- Practiced a management style regarding her handling of perceived staff performance issues which compromised the staff's ability to carry out the mission of the office.
- Violated the Standards of Ethical Conduct for Employees of the Executive Branch when she approved four projects involving participation by a former colleague, with whom the official had a close prior professional relationship.

The Under Secretary for Health agreed to take appropriate administrative action against this senior official and those members of her staff responsible for approving the use of the funds for their own or others' personal benefit. He also agreed to take several actions to correct the misuse of funds, including transferring them out of the private nonprofit corporation and properly disposing of excess funds.

III. ANALYSIS AND OVERSIGHT DIVISION

This Division has oversight responsibilities for all operations conducted by the Office of Investigations through a detailed inspection program to ensure the agency is in full compliance with the quality standards for investigations published by the President's Council on Integrity and Efficiency. The Division is also responsible for facilitating training for all Office of Investigations' employees, and procuring and maintaining highly-technical investigative equipment and other property. Additionally, the Division is the primary point of contact for law enforcement communications through the National Crime Information Center, the National Law Enforcement Telecommunications System, the Financial Crimes Criminal Enforcement Network,

and other law enforcement professional organizations.

Resources

The Analysis and Oversight Division has six FTE allocated.

Overall Performance

Output and Outcomes

- An inspection of the Southeast Field Office was conducted. Additionally, the Division took preliminary actions to conduct an external qualitative assessment review of the investigative operations of another OIG pursuant to Section 6(e) of the IG Act and the Attorney General Guidelines for Offices of IG with Statutory Authority.
- A sensitive investigation was completed on behalf of the President's Council on Integrity and Efficiency, Integrity Committee, that involved allegations of misconduct leveled at an Inspector General of another federal agency.

During the reporting period, the Division accomplished the following.

- Scheduled and/or facilitated 51 instances of training involving 43 employees for such courses as Criminal Investigator Training Program, IG Transitional Training Program, Continuing Legal Education, Interviewing Techniques, Firearms Instructor Program, Defensive Tactics Training Program, and OPM Management Training.
- Scheduled and facilitated computer-based investigative training for 19 agents at the Information Technology and Data Analysis Division in Austin, TX.
- Scheduled and facilitated reality and scenario-based training for 21 VA OIG firearms instructors.
- Participated in an IG Training Academy curriculum conference designed to identify recurring agency training needs and to develop a training program that will assist agencies in complying with the Attorney General's "periodic refresher" training mandate.
- Facilitated the completion of a memorandum of understanding with the Federal Law Enforcement Training Center, Cheltenham, MD.
- Conducted 153 National Crime Information Center and National Law Enforcement Telecommunication System record checks in support of criminal investigations.

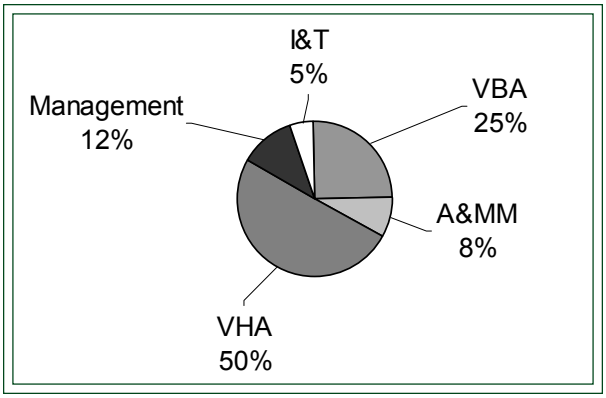
OFFICE OF AUDIT

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 17 FTE allocated for its headquarters and 159 FTE in 11 operating divisions located throughout the country. The following chart shows the allocation of resources used in auditing each of VA's major program areas.



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

Overall Performance

Outcome

- Recommendations to enhance operations correct operating deficiencies have associated monetary benefits totaling approximately $1.4 billion. In addition, contract reviews identified monetary benefits of $538 million associated with the results of preaward and postaward contract reviews.

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 4.7 out of a possible 5.0.

The following summarizes some of the audits and evaluations completed during the reporting period organized by VA component: VHA, VBA, Office of Management, Office of Information and Technology, and multiple office action.

Veterans Health Administration

Quality of Care

Issue: Part-time physician time and attendance.
Conclusion: Implementation of management controls continues to need improvement to ensure employment obligations are met.
Impact: Strengthened controls over time and attendance.

The OIG conducted an unannounced follow-up at 15 VA medical facilities to reassess time and attendance practices of part-time physicians. The purpose of the follow-up was to determine the effectiveness of management controls to ensure part-time physicians were meeting their employment obligations, and to determine the implementation of selected corrective actions to address continued time and attendance problems. We found 8 percent of the part-time physicians scheduled for duty were not on duty, approved leave, or authorized absence and potentially not meeting their VA employment obligations. Time and attendance controls were generally implemented, as required. Conflict of interest controls were not established, as required.

To address these conditions, we recommended the Under Secretary for Health: (i) ensure part-time physicians receive advance approval before taking non-emergency leave and have tour of duty changes approved in writing; (ii) ensure part-time physicians fulfill their employment obligations to VA; (iii) ensure part-time physicians execute a written agreement acknowledging VA's expectations and employees' responsibilities specific to each physician and describe the amount of time allotted for clinical, administrative, research, and educational activities; (iv) periodically reassess whether physicians are appropriately utilized; and (v) ensure physicians' supervisors and managers receive a copy of VHA Handbook 1660.3 and sign the acknowledgement form. The Under Secretary for Health agreed with the findings and recommendations and provided acceptable implementation plans. *(Follow-Up of the VHA's Part-Time Physician Time and Attendance Audit, 03-02520-85, 2/18/04)*

Issue: Anesthesiology residency program.
Conclusion: Residents received dual compensation and worked excessive hours.
Impact: Strengthened controls over the program.

The OIG evaluated the anesthesiology residency program to assess the merit of an anonymous complaint regarding residents' moonlighting activities. The complainant alleged that: (i) since residents are not allowed to engage in moonlighting for pay in their medical specialty, the health care system staff circumvented this prohibition by hiring University of California, Los Angeles (UCLA), anesthesiology residents as "airway experts," instead of "anesthesiologists;" (ii) the health care system pays moonlighting UCLA anesthesiology residents an additional $50 an hour to provide coverage on weekends and nights, even though the residents are already compensated for their duty hours; and (iii) several moonlighting UCLA anesthesiology residents work 36-hour shifts, even though this practice is prohibited.

We did not substantiate the allegation that health care system staff circumvented policies prohibiting

anesthesiology residents from moonlighting in their medical specialty, because the residents were already trained, licensed, credentialed, and privileged to perform the procedures required by their moonlighting activities. However, we substantiated allegations that UCLA anesthesiology residents received additional pay for their duty hours and they worked excessive hours. To improve operations the Acting Director needed to ensure that: (i) the Department of Anesthesiology monitors moonlighting anesthesiology residents to ensure they do not receive additional compensation for duty hours already covered under the residency training program disbursement agreement; (ii) anesthesiology residents' timesheets are current, accurate, complete, and approved by residents' supervisors, in accordance with VHA policy; and (iii) anesthesiology residents' duty and moonlighting hours are coordinated with the affiliated university, documented, monitored, and evaluated on a daily basis to ensure compliance. The Acting Director agreed with the recommendations and provided acceptable improvement plans. *(Evaluation of Allegations Regarding the Anesthesiology Residency Program at the VA Greater Los Angeles Healthcare System, 03-00810-89, 2/25/04)*

Data Validity

Issue: Compliance with Public Law 107-135.
Conclusion: Data used for reporting lacks adequate support.
Impact: Accurate data

The review was conducted to comply with the VA Health Care Programs Enhancement Act of 2001 (Public Law 107-135) that requires the OIG audit each annual special disabilities capacity report and submit a certification to Congress as to its accuracy. We reviewed the 26 tables included in the VA Fiscal Year (FY) 2002 special disabilities capacity report. Results of our review showed 13 of 26 tables contain data that are unreliable and frequently contradictory. All 13 tables address staffing and related information for specialized mental health programs. All except one table rely on inconsistent cost distribution report data. We also found one table listing non-pharmacy mental health expenditures that contained erroneous data, which was corrected and reissued by the VHA during the review. We found the remaining 12 tables were adequately supported by data in VHA record systems.

We recommended the Under Secretary for Health ensure reporting and data validation mechanisms for specialized mental health programs are strengthened in order to more accurately present the staffing and related data required for the special disabilities capacity report. The Under Secretary for Health agreed with the review findings and recommendation and provided responsive implementation plans. *(Review of Department of Veterans Affairs FY 2002 Special Disabilities Capacity Report, 03-01356-10, 10/24/03)*

Veterans Benefits Administration

Data Integrity

Issue: Compensation and pension data integrity problems.
Conclusion: Allegations were not substantiated.
Impact: Accurate data.

The OIG conducted an evaluation of alleged compensation and pension data integrity problems at the Salt Lake City VARO. The purpose of the evaluation was to determine whether the VARO's Veterans Service Center staff had manipulated end products (EP), and, if so, identify the nature of the manipulation; how it was identified; and what, if any, remedial or disciplinary actions were taken in response to the manipulation. Also, the evaluation was to determine whether VBA had adequate staff and technical expertise to properly identify and address data integrity problems.

We concluded that the allegations of data manipulation and data integrity problems at the VARO were not substantiated. Although reviews conducted by the VBA's Western Area Office and the OIG identified improper EPs, the improper EPs resulted from management and staff errors rather than from a concerted, systematic effort on the part of the staff to manipulate EP productivity and timeliness data. We also noted VBA had sufficient staffing and technical expertise at the program and area office level to identify potential data integrity problems, and appropriate actions were taken when the improper use of an administrative EP was identified at the VARO. To improve operations, the VARO needed to share our evaluation results with the staff to assist them in addressing EP errors and improving the accuracy of the VARO's EP data. The VBA Area Director agreed with the evaluation findings and provided responsive implementation plans. *(Evaluation of Alleged Compensation and Pension Data Integrity Problems at VARO Salt Lake City, UT, 03-01950-31, 11/25/03)*

Office of Management

VA's Consolidated Financial Statements (CFS)

Issue: VA's CFS for FYs 2003 and 2002.
Conclusion: Audit resulted in an unqualified opinion, but significant control weaknesses and noncompliance items still remain.
Impact: Improved stewardship of VA assets and resources.

The OIG contracted with the independent public accounting firm Deloitte & Touche LLP to perform the audit. The OIG defined the requirements of the audit, approved the audit plans, monitored the audit, and reviewed the draft reports. The independent auditors' report provided an unqualified opinion on VA's FY 2003 and 2002 CFS. We agree with the auditors' opinion and with the conclusions in the related report on VA's internal control over financial reporting and compliance with laws and regulation.

The auditor's report on internal control identifies 4 reportable conditions, of which 2 are material weaknesses. The two material weaknesses are: (i) information technology security controls and (ii) integrated financial management system. The two reportable conditions are: (i) operational oversight and (ii) medical malpractice claims data. Three of the four findings were reported last year.

The medical malpractice claims data is the new reportable condition for FY 2003. During FY 2003, VA management has taken corrective action to eliminate the following two reportable conditions reported in the FY 2002 audit report: (i) loan guaranty business process, and (ii) application program and operating system change controls.

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

The Assistant Secretary for Management agreed with the reported findings and recommendations. We will follow-up on these findings and evaluate implementation of corrective actions during our audit of VA's FY 2004 CFS. *(Report of the Audit of the Department of Veterans Affairs CFS for FYs 2003 and 2002, 03-01237-21, 11/14/03)*

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

Our report contains the audit opinion, the report on internal control over financial reporting, and the report on compliance with laws and regulations. The Enterprise Centers' management contracted with the independent public accounting firm Brown & Company CPAs, PPLC to perform the audit of VA's Franchise FY 2003 CFS. The independent auditor's report provided an unqualified opinion on VA's Franchise Fund FY 2003 CFS. The Franchise Fund management defined the requirements of the audit; and the OIG reviewed the audit plans, monitored the audit, and reviewed the draft reports.

The auditor's report on internal control over financial reporting identifies one material weakness concerning information technology security controls. This finding and related recommendation were included in the Department's FYs 2003 and 2002 CFS audit reports.

The report on compliance with laws and regulations discloses that VA, as a whole, is not in substantial compliance with the financial management systems requirements of the Federal Financial Management Improvement Act of 1996. The Franchise Fund uses VA's financial management systems to prepare its financial statements. The auditors' tests of compliance disclosed no instances of noncompliance with other laws and regulations specified in OMB Bulletin No. 01-02. We will follow-up on the findings during the audits of the Franchise Fund's FY 2004 CFS and VA's FY 2004 CFS. *(Audit of the Department of Veterans Affairs' Franchise Fund CFS for FYs 2003 and 2002, 03-02159-52, 12/19/03)*

Issue: Allegations of improper Medical Care Collection Fund (MCCF) billings.
Conclusion: Improper billings occurred.
Impact: VHA's planned actions should ensure propriety of future billings.

We reviewed billing practices to determine the validity of allegations of improper and fraudulent MCCF billings to American Association of Retired Persons (AARP). Our review substantiated the allegations of improper, but not fraudulent, billing. Misinterpretations of VHA coding/billing guidelines by facility staff, mistakes, and poor communication among facility MCCF, Health Information Management, and Office of Compliance and Business Integrity staff contributed to the improper billings.

We recommended the VISN Director monitor implementation of corrective actions to ensure accuracy and propriety of bills submitted to AARP and refund of overpayments. We also recommended the Under Secretary for Health monitor follow-up actions, provide appropriate guidance to ensure that solutions to current billing issues are implement nationwide, and ensure an effective process to resolve promptly future billing issues with AARP. The Under Secretary for Health and the VISN 1 Director agreed with the recommendations and provided responsive implementation plans. *(Evaluation of Medical Insurance Billing Practices at VAMC Bedford and Northampton, MA, 03-00396-36, 12/1/03)*

Issue: Attestation of VA's accounting for expenditures on National Drug Control Program activities.
Conclusion: The attestation identified a significant required increase in VA's reported expenditures associated with Program activities.
Impact: Financial reporting and control.

We reviewed the VA Detailed Accounting Submission relating to obligations on National Drug Control Program activities. Our review was conducted consistent with standards for attestation engagements established by the American Institute of Certified Public Accountants. We concluded that:

- Estimated obligations of $845.7 million that should be reported for FY 2003 are reliable based on our review and adjustment of reported patient counts, and review of the reporting methodology used by VHA to assure ourselves that the reporting methodology approved by the Office of National Drug Control Policy is appropriately used. Patient counts are important because they form the basis for calculating expenditures. Additionally, as reflected in prior attestation reports, our concerns relating to the unreliability of cost accounting data produced by VA financial systems have not been satisfied. VA's independent auditors have recommended VA cease using the cost system used to produce the obligations data.

- All activities conducted by VA having a drug-related nexus are not reflected in the drug methodology. However, the costs associated with unreported drug-related activities may not be material relative to the aggregate costs reported.

Except for the preceding qualification, nothing came to our attention that caused us to believe the Detailed Accounting Submission is not presented in conformity with the Office of National Drug Control Policy reporting methodology. *(Attestation of the Department of Veterans Affairs Detailed Accounting Submission, 04-00897-113, 3/17/04)*

Preaward Contract Reviews

Issue: Federal Supply Schedule (FSS) vendors' best prices.
Conclusion: Vendors can offer better prices to VA.
Impact: Potential better use of $516.5 million.

Preaward reviews of 28 FSS and direct delivery offers made recommendations for potential better use of $516.5 million. Recommendations to negotiate lower contract prices were made because the vendors were not offering the most favored customer prices to FSS customers when those same prices were extended to commercial customers purchasing under similar terms and conditions as the FSS.

Issue: Health care resource contracts.
Conclusion: VA can negotiate reduced contract costs.
Impact: Potential better use of $6.5 million.

We completed reviews of 17 proposals from VA affiliated medical schools involving the acquisition of scarce medical specialists' services. We concluded the contracting officers should negotiate reductions of $6.5 million to the proposed contract costs because of differences between the proposed costs for the services solicited and the costs the affiliate could justify.

Postaward Contract Reviews

Issue: Contractor overcharges for pharmaceuticals and medical supplies.
Conclusion: Overcharges were disclosed.
Impact: Recovery of more than $15.2 million.

We completed seven reviews of vendors' contractual compliance with the specific pricing provisions of their FSS contracts. We also completed three drug pricing Public Law 102-585 compliance reviews at pharmaceutical vendors. The reviews resulted in recoveries amounting to $15.2 million.

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

Office of Information and Technology

Security Controls

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

The audit evaluated VA's information security controls and security management. Based on the results of the FY 2003 information security audit, we concluded VA has made insufficient progress in improving its information security posture. VA is not in compliance with the requirements of the Federal Information Security Management Act. VA's information security vulnerabilities have not been adequately addressed because the Department did not complete necessary corrective actions in response to our audit findings. Serious security vulnerabilities have continued to exist over a multi-year period that place VA systems, data, and delivery of services to the Nation's veterans at risk. This risk was demonstrated this year with the virus/worm incursions that disrupted vulnerable Department automated systems.

The Department has not been able to effectively address its significant information security vulnerabilities and reverse the impact of its historically decentralized management approach. VA's security remediation efforts continue to be ineffective with inadequate facility compliance with established security policies, procedures, and guidelines. As a result, significant information security vulnerabilities continue to place the Department at risk of the following.

- Denial of service attacks on mission critical systems.
- Disruption of mission critical systems.
- Unauthorized access to and improper disclosure of data subject to Privacy Act protection and sensitive financial data.
- Fraudulent payments of benefits.
- Fraudulent receipt of health care benefits.

Based on the audit results, VA information security should continue to be identified as a Department material weakness area under the Federal Managers' Financial Integrity Act. We recommended a number of operational changes that will help improve VA's information security posture, ensure effective control over sensitive information, ensure continuity of operations, and support the Department's missions of providing health care and delivering benefits to the Nation's veterans. The Acting Assistant Secretary for Information and Technology agreed with the findings and recommendations, and provided acceptable implementation plans. *(Audit of the Department of Veterans Affairs Information Security Program, 02-03210-43, 12/9/03)*

Issue: VA's information security program.
Conclusion: VA was not prepared for the Blaster Worm attack.
Impact: Improved automated data processing security.

We evaluated the effectiveness of the installation of the Microsoft Blaster Worm security patch for computer systems in the VA. The evaluation found several deficiencies. Dissemination of the detailed findings is restricted due to security reasons. We made several recommendations to

the Acting Assistant Secretary for Information and Technology. The Acting Assistant Secretary agreed with the findings and recommendations, and provided an acceptable implementation plan. *(Evaluation of the Department of Veterans Affairs Installation of the Microsoft Blaster Patch, 03-02970-55, 1/9/04)*

Multiple Office Action

Issue: VAMC procurement of medical, prosthetic, and miscellaneous operating supplies.

Conclusion: VA could reduce costs by $1.4 billion over 5 years by using contract sources more effectively and awarding more national-scope contracts.

Impact: Better use of funds.

The OIG performed an audit to determine if VAMCs effectively purchased medical, prosthetic, and miscellaneous operating supplies using the best available sources, such as VA national contracts. VHA facilities are required to follow a purchasing hierarchy under which VA national contracts, blanket purchase agreements (BPAs), and FSS contracts are the most preferred sources and the open market is the least preferred source. We evaluated purchases of 50 representative supply products at 15 VAMCs.

Large proportions of supply purchases were not made from the best sources. Of the $23.4 million the VAMCs spent on products available from contracts and BPAs, only $14.2 million (60.7 percent) of these purchases were made from the best contract/BPA sources. The remaining $9.2 million (39.3 percent) was spent on purchases from the open market or from higher priced contracts.

The audit also found VA needed to award more national-scope contracts that will allow VA to best leverage its buying power. Eleven (22 percent) of the 50 products reviewed were only available on the open market and were not covered by contracts or BPAs. In addition, 34 products (68 percent) were covered by FSS contracts, but were not covered by VA national contracts or BPAs.

Based on our review at the 15 VAMCs, we estimated a VHA-wide purchasing savings rate of 9 percent and a contracting savings rate of 6 percent. Extrapolated to total VHA supply purchases, these rates equate to cost reductions of about $213.5 million a year. Over the next 5 years (FYs 2004–2008), taking into account inflation and increased supply usage, the savings would be about $1.4 billion.

To improve procurement practices, we recommended the Under Secretary for Health: (i) direct VAMCs to fully implement the purchasing hierarchy, (ii) implement performance monitors to ensure VAMCs appropriately use each hierarchy source, and (iii) require National Acquisition Center approval of local supply contracts. We also recommended the Under Secretary for Health and the Assistant Secretary for Management work together to: (i) ensure purchasing staff are trained on the requirements of the purchasing hierarchy; and (ii) increase efforts to award new national contracts and BPAs for supply products. The Under Secretary for Health and the Assistant Secretary for Management agreed with the recommendations and provided generally acceptable implementation plans. *(Audit of VAMC Procurement of Medical, Prosthetic, and Miscellaneous Operating Supplies, 02-01481-118, 3/31/04)*

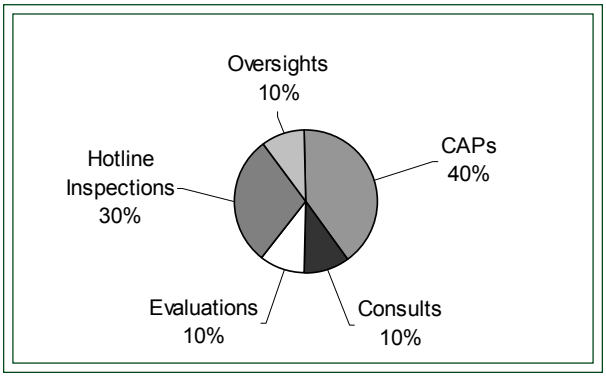
OFFICE OF HEALTHCARE INSPECTIONS

Mission Statement

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

Resources

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



Overall Performance

Output

- Participated in 18 CAP reviews to evaluate health care issues and made 59 recommendations and 59 suggestions that will improve operations and activities, and the care and services provided to patients.

- Completed two summary evaluations and made seven recommendations to improve patient care and efficiencies in the Homemaker and Home Health Aide Program and improve security over VA potable and waste water systems.

- Completed 16 Hotline cases, which consisted of reviews of 78 issues. Administratively closed 2 cases and issued reports on the remaining 14 cases. Made 52 recommendations that will improve the health care and services provided to patients.

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

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

- We completed 16 technical reviews on recommended legislation, new and revised policies, new program initiatives, and external draft reports.

- We reviewed the responses to 93 Hotline cases consisting of 133 issues that were referred to VHA managers for review.

Outcome

- Overall OHI made or monitored the implementation of 118 recommendations and 59 suggestions to improve the quality of care and services provided to patients and their families. VHA managers agreed with all of our recommendations and provided acceptable implementation plans. VHA implementation actions will improve clinical care delivery, management efficiency and patient safety, and will hold employees accountable for their actions.

Veterans Health Administration

Summary Evaluations

Issue: VHA Homemaker and Home Health Aide Program.
Conclusion: Prior OIG recommendations were not implemented.
Impact: Improved patient care and reduced costs.

As part of the OIG's CAP reviews, we inspected the program at 17 VA medical facilities. Fourteen percent of the patients receiving program services in our sample did not meet clinical eligibility requirements. Initial assessments by clinicians were often no more than referrals to the program. The assessments rarely included documentation of actual evaluations by all required interdisciplinary team members, and did not thoroughly document patients' disabilities, dependencies, and needs for services. Some facilities had many patients on waiting lists and did not always consider clinical eligibility or patients' needs. Programs with scarce resources and wait-listed patients cannot afford to serve ineligible patients or patients not requiring these services.

To enhance controls, VHA managers need to issue policy for the provision and acquisition of program services to improve the quality of care and to maximize the use of resources. This policy should address assessment and monitoring of needs, including consideration of the patient's clinical eligibility and special monthly compensation or pension status. VHA managers also need to establish a method of benchmarking rates for the acquisition of program services. If VHA had established benchmark rates as recommended in a 1997 OIG report, the program could have, on average, redirected about $10.7 million annually to treat additional patients.

We made two recommendations. The Under Secretary for Health concurred and provided responsive implementation plans. *(Healthcare Inspection, Evaluation of VHA Homemaker and Home Health Aide Program, 02-00124-48, 12/18/03*)

Issue: VA potable and waste water systems security.
Conclusion: VHA needs to standardize security requirements and coordinate with the EPA.
Impact: Improved water infrastructure security.

We conducted a survey for the EPA to review security over VA potable and waste water systems, and the degree of VA coordination with EPA concerning those systems. The purpose of the review was to determine whether VA is actively and consistently identifying and addressing risks to VA-owned or leased utilities or systems through vulnerability assessments, design enhancements, emergency response plans, and security improvements.

The VHA facilities we surveyed described varying degrees of effort in conducting water system assessments and security reviews. No facility reported that it coordinated these efforts with the EPA or the Department of Homeland Security. The Under Secretary for Health needs to standardize security requirements for protecting water infrastructures, and coordinate efforts with

EPA to assess and implement security of potable and waste water systems on VHA properties to reduce potential vulnerabilities to terrorist threats. These actions would assist the Department of Homeland Security in unifying Federal efforts for addressing national water infrastructure concerns, including development of critical infrastructure personnel surety programs.

We made three recommendations. The Under Secretary for Health concurred and provided responsive implementation plans. In their response, they stated that currently available EPA guidance is not adequate for addressing VHA needs, and that VHA would contact EPA for their assistance in developing guidance on water and wastewater security. *(Healthcare Inspection, Survey of Efforts to Safeguard VA Potable and Waste Water Systems, 03-01743-114, 3/18/04)*

Healthcare Inspections

Issue: Allegations of substandard care.
Conclusion: Care procedures for walk-in patients need improvement.
Impact: Less than optimal medical outcome for this veteran.

We conducted this inspection in response to allegations of substandard care at VAMC Philadelphia. The complainant alleged that in July 2002: (i) his primary care physician inadequately examined his diabetic foot wound and did not prescribe oral or topical antibiotics; and (ii) podiatry clinic clinicians did not evaluate his medical condition when he presented for treatment as a walk-in patient, which resulted in physicians later having to amputate part of his left foot. We interviewed the complainant, the VAMC executive and clinical managers, the patient advocate, outpatient clinicians, and other employees who were knowledgeable about the complainant's treatment. We reviewed the complainant's medical record, VAMC policies and procedures, and other documents pertaining to the allegations.

We determined the primary care physician properly examined and treated the complainant's foot condition, prescribed an appropriate antibiotic, and ordered appropriate follow-up podiatry care. However, we concluded the complainant did not receive timely and appropriate care because the local procedures to care for walk-ins resulted in the complainant having to present to three different clinical areas and resulted in an ER wait of 5 hours. Despite the complainant's frustration over his long wait for care, the complainant made a poor decision when he left the ER prior to having his infected foot examined.

We concluded the walk-in policies, combined with the complainant's decision to leave the ER, resulted in a less than optimal medical outcome for this veteran. The failure of the complainant to obtain his antibiotic from the pharmacy and to begin timely antibiotic therapy, in conjunction with the lack of care associated with medical center impediments, resulted in missed opportunities to control the complainant's foot infection prior to the necessity for amputation. Our inspection indicated the primary care physician was hired as a part-time staff physician who was scheduled to work one afternoon clinic a week and one morning clinic a month. It does not appear VA is making proper use of this clinician's time.

We made four recommendations. The VISN 4 Director concurred and provided responsive implementation plans. *(Healthcare Inspection, Patient Care Issues, VAMC Philadelphia, PA, 03-03260-01, 10/6/03)*

Issue: Allegation that patient received incorrect medication resulting in an adverse drug event.
Conclusion: Managers needed to contact patient and discuss his care and outcome.
Impact: Improved communication between clinicians and patients.

We reviewed a complainant's allegation that he received the wrong blood transfusion because he was wearing another patient's wristband. The complainant also alleged another patient received the wrong medication which resulted in an adverse drug event. We could not substantiate or refute the allegation that the complainant wore an identification wristband that displayed the name of another patient on it. Also, we did not substantiate that the complainant received the wrong blood transfusion.

We substantiated the allegation that another patient received incorrect medication which resulted in an adverse drug event. After receiving the medication, the patient developed shortness of breath, tachycardia, and welts on his back. VA clinicians immediately responded and resolved the patient's reactions to the wrong medication. While we did not substantiate that the patient received inappropriate care after the event, we determined facility managers needed to contact the patient and discuss his care and outcome. Both cases illustrated the importance of clear, timely communication with patients when they present their concerns to facility managers.

We made three recommendations to management. The VISN and Healthcare System Directors concurred with the recommendations and provided responsive implementation plans. *(Healthcare Inspection, Quality of Care Issues, VA Long Beach Healthcare System, Long Beach, CA, 03-01915-02, 10/7/03)*

Issue: Allegations that patient died because of inadequate medical care.
Conclusion: Patient did not receive optimal care.
Impact: Incident appeared to be isolated and corrective actions should reduce the possibility of reoccurrence.

We initiated an inspection in response to allegations that a patient died because of inadequate medical care provided to him when he presented to the VAMC Dayton ER. The complainants also alleged the patient received substandard care at the Richmond, IN Community-Based Outpatient Clinic.

The patient went to the outpatient clinic to have a catheter removed; however, clinicians were unsuccessful inserting the replacement catheter. They transferred the patient to the VAMC ER where the catheter was inserted. However, a routine blood test showed his potassium level was dangerously low and the physician gave the patient a single dose of oral potassium, but did not recheck the level before discharge. The patient left the ER and went to the outpatient pharmacy to fill his prescriptions. While waiting in line to obtain his medications, he collapsed and died a short time later.

We substantiated the allegation that the VAMC physician did not meet the standard of care and

the patient did not receive adequate medical care. We found there were no written guidelines or policies requiring nurses to obtain physician consultations, but the generally accepted practice at the clinic was for nurses to consult physicians about their patient encounters. The incident appeared to be isolated and the VAMC Director initiated internal corrective actions that should reduce the possibility of reoccurrence. Therefore, we did not make additional recommendations concerning the incident.

We recommended the VISN Director require the VAMC Director to: (i) develop and implement a policy that requires clinic nursing employees to contemporaneously inform attending physicians about all clinical patient encounters; and (ii) inform the deceased patient's family members of the circumstances surrounding his death and make them aware of their rights to seek redress. The VISN and VAMC Directors concurred with the recommendations and provided responsive implementation plans. *(Healthcare Inspection, Patient Care Incident, VAMC Dayton, OH, 03-01644-15, 10/29/03)*

Issue: Allegations of questionable medical treatment.
Conclusion: Treatment interventions needed improvement.
Impact: Improved timeliness and pain management.

We conducted the inspection in response to allegations of questionable medical treatment, poor communications, and Health Insurance Portability and Accountability Act privacy violations. Overall, we found the patient received adequate medical care; although, we identified lapses in the timeliness of some interventions. We could not confirm or refute the complainant's allegation that he received inadequate pain management during his hospitalization, but we found documented lapses in the treatment of his pain. There was evidence in the medical record documenting that physicians communicated with the complainant about his plan of care. We could not substantiate the complainant's allegation that his inpatient physician was rude to him, but the physician was firm in advising the patient regarding his course of care. Although the complainant's privacy during an eye clinic evaluation should have been considered, we did not find evidence that his privacy was violated.

We were assured by the Acting VAMC Director and quality manager that they would discuss the importance of timeliness and pain management with the involved inpatient clinicians and would take all appropriate measures to meet the complainant's needs. The patient was assigned a new primary care provider and is currently receiving treatments from a dermatologist and an ophthalmologist. Therefore, we made no recommendations. *(Healthcare Inspection, Patient Care, Communication, and Privacy Issues, Overton Brooks VAMC, Shreveport,LA, 03-02160-016, 11/4/03)*

Overton Brooks VA Medical Center
Shreveport, LA

Issue: Patient care allegations.
Conclusion: Lapses in medical record documentation.
Impact: Importance of documentation discussed with all applicable personnel.

We conducted an inspection in response to allegations that a patient developed pressure ulcers because nurses failed to turn and bathe the patient, and the patient was discharged too early. We also reviewed allegations that employees did not wash their hands or use gloves when treating patients and did not clean beds between patients at the VA facility.

VA New Jersey Health Care System
East Orange, NJ

We did not substantiate the complainant's allegation that the patient developed pressure ulcers because nurses failed to follow turning or bathing procedures. We also did not substantiate that the patient was discharged too early, however, there were lapses in medical record documentation which were addressed with applicable employees. We could not refute or confirm the allegation that physicians and nurses did not wash their hands or wear gloves when caring for patients, as we had no direct evidence of this alleged practice during the time the patient was receiving care. However, the facility did have extensive policy on hand-washing procedures and during our visit, we observed employees using gloves when caring for patients. Similarly, we could not refute or confirm the allegation that employees did not clean beds after patients were discharged. We found the facility had a comprehensive bed-cleaning policy, used cleaning logs and tags to track compliance, and were following policy.

We discussed the issues in detail with facility management and they assured us they would discuss the importance of documentation and the above issues and procedures with all applicable personnel. Therefore, we made no recommendations. *(Healthcare Inspection, Patient Care and Infection Control Issues, VA New Jersey Health Care System, East Orange, NJ, 03-02799-30, 11/24/03)*

Issue: Medical care foster home program.
Conclusion: Policy guidance and program oversight needed improvement.
Impact: Improved monitoring practices and controls.

We reviewed the Central Arkansas Veterans Healthcare System's medical care foster home program at the request of the VHA Geriatrics and Extended Care program officials. The program was designed to serve patients with severe chronic illnesses who do not have the necessary resources (housing or family support) to remain at home, but who are resistant to nursing home placement. We found that as a new clinical initiative, the program needed specific policy guidance. Since the medical care foster home program most closely resembled VHA's Community Residential Care Program, we used the prescribed monitor and control procedures from the residential care program as a basis of comparison.

We found the medical care foster home program could benefit from the establishment and implementation of VHA policies that will prescribe specific patient assessment, placement, and follow-up practices; home inspection requirements; and communication guidelines. We believe patient safety and care could be enhanced if procedures are established and implemented to require VA clinicians to complete interdisciplinary assessments prior to placing veterans in caregivers' homes. VA clinicians needed to provide foster home caregivers with patients' information and care instructions at the time of the placements, and assess the adequacy of patients' adjustments to their home. Because owners typically only bring one or two veterans into their homes, they are not regulated by the State. This makes it very important that VA clinicians ensure the designated homes are clean and safe.

In addition, we found some veterans in the program were rated as incompetent for VA purposes, and were also under the supervision of VBA's field examiners. VA guidelines require VHA clinicians and VBA field examiner supervisors to meet annually to discuss patients of mutual concern. Actions are needed to ensure these two groups periodically communicate for the purpose of ensuring veterans residing in the homes are adequately cared for and are safe.

Central Arkansas Veterans Healthcare System
Little Rock, AR

We made six recommendations to improve monitoring practices and controls. The VISN Director's concurred with the recommendations and provided responsive implementation plans. *(Healthcare Inspection, Medical Care Foster Home Program, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas, 03-00391-39, 12/3/03)*

Issue: Allegations of inadequate medical care.

Conclusion: Clinical evaluation and diagnostic considerations were not adequately documented in the medical record.

Impact: Inadequate documentation impeded understanding of clinicians' efforts.

We conducted an inspection to determine the validity of allegations that a patient received inadequate medical care. The complainant alleged a physician gave the patient an intravenous medication, causing an adverse reaction that led to his death. The complainant also alleged clinicians delayed treating the patient's symptoms and clinicians performed an unauthorized autopsy.

We did not substantiate any of the complainant's allegations. However, we found the details of the clinical evaluation, diagnostic considerations, and clinical reasoning that underpinned the patient's care were not adequately documented in the medical record. Inadequate documentation impeded tracking and understanding of clinicians' efforts from the medical record alone. We found the autopsy was authorized by the next-of-kin.

We made one recommendation. The VISN Director concurred with the recommendation and provided a responsive implementation plan. *(Healthcare Inspection, Alleged Medical Treatment Issues, Houston VAMC, Houston, TX, 03-01526-64, 1/12/04)*

Issue: Allegations of substandard anesthesia care and not reporting adverse incidents.
Conclusion: Substantiated nine significant patient safety issues.
Impact: Improved patient safety.

We conducted an inspection to determine the validity of allegations of substandard anesthesia care. The complainant alleged no one reviewed the appropriateness of using sedation and analgesia medications and reversal agents in areas other than the operating room or assessed the competence of non-anesthesia providers, and there were no guidelines for nurses who gave sedation medications. In addition, the complainant alleged anesthesia employees practiced without advanced cardiac life support certifications, and intensive care unit clinicians inappropriately used medications for anesthesia use. The complainant further alleged managers had not reported adverse incidents to the safety officer, attempting to cover up medical and nursing errors resulting from time pressures in the operating room.

We substantiated nine significant patient safety issues, including allegations that clinical managers had not monitored the practices of non-anesthesia providers who administered sedation and anesthetic medications or reversal agents, clinicians were using a medication (etomidate) that was restricted by facility policy for use by anesthesiology and ER physicians only, and some anesthesiology section clinicians did not have the required certifications. We did not find any evidence to suggest reports of adverse patient incidents were destroyed as part of a cover-up, but we substantiated the allegation that patient incident reports were not always forwarded to the patient safety officer.

We made thirteen recommendations. The VISN and System Directors concurred with the recommendations and provided responsive implementation plans. *(Healthcare Inspection, Anesthesia Management and Patient Care Issues, New Mexico VA Healthcare System, Albuquerque, NM, 03-01914-68, 1/14/04)*

Issue: Allegation that physicians deviated from the standard of care.
Conclusion: Provided appropriate care; however, attending physician had inadequate personal interaction with the patient and family, and managers did not timely communicate compensation options to the family.
Impact: Improved communication between clinicians and patient.

We conducted this inspection in response to an allegation that physicians at the VAMC deviated from the standard of care during the treatment of

Iowa City VA Medical Center
Iowa City, IA

a patient. The purpose of the inspection was to determine the validity of the allegation. The issues reviewed were: (i) deviation from the standard of care during the treatment of the patient; (ii) an inappropriate trainee surgeon in the operating room; (iii) inadequate attending physician involvement with the patient and family; and (iv) failure to properly notify the family regarding their rights to compensation.

We did not substantiate the allegation that physicians deviated from the standard of care or that it was inappropriate for a trainee surgeon to be in the operating room. To improve operations, the system managers needed to communicate the requirements of VHA Handbook 1400.1, which governs resident supervision, to all attending physicians and require compliance with all aspects of this directive; and develop procedures to fully inform patients and their families of their options for compensation under 38 U.S.C. 1151 and a tort claim. The VISN 23 Director agreed with the recommendations and provided responsive implementation plans. *(Healthcare Inspection, Quality of Care Issues, Iowa City VAMC, Iowa City, Iowa, 03-01423-70, 1/16/04)*

Issue: Allegations of poor patient care.
Conclusion: Substantiated four of five patient care issues.
Impact: Improve attending surgeons' compliance with resident supervision handbook, and monitor compliance with security of potassium solutions.

We conducted an inspection to determine the validity of allegations of poor patient care. An anonymous complainant alleged that: (i) attending surgeons did not assess patients prior to surgery; (ii) attending surgeons routinely arrived after anesthesia had been started and after the surgical residents had begun the surgical procedures; (iii) cardiology on-call response was inappropriately delayed in one surgical case; (iv) anesthesiologists occasionally left potassium vials unsecured in the operating room following cardio-thoracic (open-heart) surgery; and (v) clinicians did not obtain proper surgical consent in one case.

We substantiated four of the five patient care issues, including allegations that attending surgeons did not consistently document that they assessed patients prior to surgery, surgical managers did not consistently require attending surgeons be present during their patients' operations, cardiology support was inappropriately delayed in one incident, and potassium vials had not been properly accounted for immediately following open-heart surgery. We did not substantiate that improper surgical consent was obtained in the case cited by the complainant.

Greater Los Angeles Healthcare System
Los Angeles, CA

To improve operations, managers needed to ensure attending surgeons' compliance with the provisions of the VHA Resident Supervision Handbook and develop procedures and monitor anesthesiologists' compliance with the security of potassium solutions. The VISN Director

concurred with the recommendations and provided responsive implementation plans. *(Healthcare Inspection, Patient Care Issues, Greater Los Angeles Healthcare System, Los Angeles, CA, 03-02849-81, 2/6/04)*

Issue: Allegation of non-authorized patient research.
Conclusion: No evidence of unauthorized patient research, but commodity standardization policy training is needed.
Impact: Improved patient care.

We conducted an inspection to determine the validity of allegations concerning abuse of a patient during an endoscopy procedure. The complainant alleged the physician took extra tissue in order to do parallel testing, which is considered research, and therefore, required informed consent and institutional review board approval.

We concluded no extra tissue was obtained during the procedure. We further concluded the physician had obtained proper consent for the procedure and that parallel testing is not considered research, and therefore, not subject to board approval. We recommended the facility: (i) conduct in-service training for appropriate clinicians to ensure compliance with commodity standardization policy; and (ii) establish a quality improvement monitor to ensure compliance with policy. The VISN and facility leadership concurred with the recommendations and provided responsive implementation plans. *(Healthcare Inspection, Patient Care Issues at the Samuel S. Stratton Department of Veterans Affairs Medical Center, Albany, NY, 03-01744-102, 3/10/04)*

Issue: Negligence and substandard care at a community nursing home.
Conclusion: Actions were needed to ensure the patient received the care needed.
Impact: Improved discharge planning processes and patient safety.

We initiated an inspection in response to allegations that a patient was neglected and received substandard care at a community nursing home under contract with the medical center. We concluded nursing home employees did not provide the care to this patient that was outlined in the medical center discharge summary. The patient's medical center treatment team and the nursing home clinicians had different expectations about the level of care this patient was to receive. Medical center clinicians did not ensure that this patient's transfer resulted in the continuous delivery of required health care to this patient.

We recommended managers: (i) ensure clinicians review the care other VA patients have and are receiving in this nursing home; (ii) amend the discharge planning process to require clinicians to verify that all required care is available for patients upon admission to the home; (iii) review the medical center's overall oversight process; and (iv) seek advice from General Counsel regarding the need to advise family members to seek compensation. The VISN and VAMC Directors concurred with the recommendations and provided responsive implementation plans. *(Healthcare Inspection, Contract Nursing Home Patient Care Issues, VA Pittsburgh Healthcare System, University Drive Division, Pittsburgh, PA 03-02167-101, 3/10/04)*

Issue: Quality of care, patient information security, unsanitary conditions, and rude behavior by employees toward patients.

Conclusion: Substantiated allegations of inadequate security of information, unsanitary conditions, lack of assistance with check in, and failure to make needed repairs, and also witnessed rude behavior by employees.

Impact: Improve security, cleanliness, patient care, and employee professionalism.

We conducted this inspection in response to allegations from a relative of an active duty soldier injured in Iraq. The allegations included: (i) extensive waiting time in outpatient radiology, (ii) rude behavior by employees during the patient's visit, (iii) improper supervision of patients waiting for appointments, (iv) inadequate security of confidential patient information, (v) unsanitary conditions in the environment of care (e.g., live ants were observed in outpatient treatment areas), (vi) lack of staff to assist patients with the check in process in outpatient radiology, (vii) failure to change linens on radiology tables between patient examinations, and (viii) failure to make needed repairs (e.g., replacing missing ceiling tiles and eliminating hanging cords from the ceiling).

We substantiated the allegations of inadequate security of confidential patient information, unsanitary conditions in the environment of care, lack of employees to assist patients with check in processes in outpatient radiology, and failure to make needed repairs. We did not substantiate the allegations of extensive waiting time in outpatient radiology and improper supervision of patients. However, we found inconsistent linen changing practices, which could result in linens not being changed between patients. We could not substantiate or refute the allegation that the patient was treated rudely during visits. However, we did witness episodes of rude behavior by employees toward patients, failure of employees to wear their identification badges, and employees eating in patient treatment areas. We also found that managers failed to enforce egress requirements in hallways.

We made seven recommendations. The Director concurred with the recommendations and provided responsive implementation plans. *(Hotline Inspection, Quality of Care, Patient Information Security, and Environment of Care Issues, Edward Hines, Jr. VA Hospital, Hines, IL, 03-02306-107, 3/15/04)*

Edward Hines, Jr., VA Hospital
Hines, IL

Issue: Suspicious death.
Conclusion: The patient had inappropriate access to narcotic drugs and documentation deficiencies.
Impact: Improved patient safety and medical record documentation.

We conducted this inspection in response to allegations that a patient died of a drug overdose while receiving care on an inpatient unit. Other allegations included: (i) the medical examiner was not notified in a timely manner of the death, (ii) irregularities in the manner in which the body was handled, (iii) poor and insensitive communication with the patient's family members, (iv) quality of care deficiencies, and (v) failure to notify patient's spouse of a previous near-fatal drug overdose.

We concluded the patient had inappropriate access to narcotic drugs and managers had not notified the medical examiner in a timely manner. We also found the patient's medical record had the following documentation deficiencies: (i) inadequately descriptive progress notes depicting nursing involvement in his treatment, and (ii) inadequate documentation of patient safety observation checks. Overall, employees made good faith efforts to treat this patient's complex medical and psychiatric problems.

We made three recommendations. The Director concurred with the recommendations and provided responsive implementation plans. *(Healthcare Inspection, Drug Overdose, VAMC Hampton, VA, 03-02149-221, 3/31/04)*

VA Medical Center
Hampton, VA

OFFICE OF MANAGEMENT & ADMINISTRATION

Mission Statement

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

The Office of Management and Administration is responsible for a wide range of administrative and operational support functions. The Office includes five divisions.

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

II. Operational Support – Performs follow-up on implementation of OIG report recommendations; Freedom of Information Act/Privacy Act (FOIA/PA) releases; strategic, operational, and performance planning; electronic report distribution; and OIG reporting requirements and policy development.

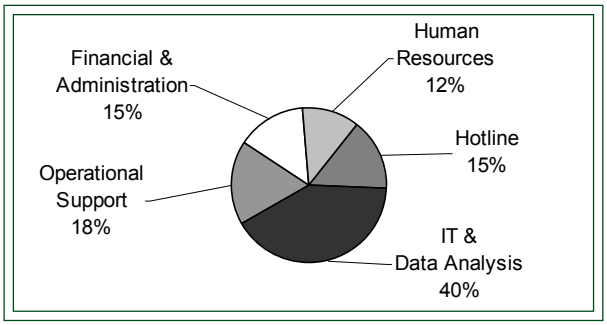
III. Information Technology (IT) and Data Analysis – Manages nationwide IT support, systems development and integration; represents the OIG on numerous intra- and inter-agency IT organizations; and does strategic IT planning for all OIG requirements. The Division maintains the Master Case Index (MCI) 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.

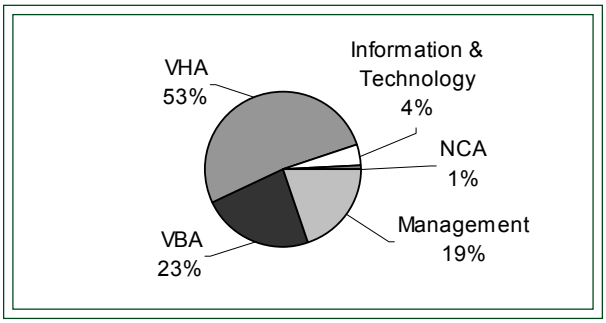
IV. Financial and Administrative Support – Responsible for OIG financial operations, including budget formulation and execution, and all other OIG administrative support services.

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

Resources

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





I. HOTLINE DIVISION

Mission Statement

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

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

Resources

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

Overall Performance

During the reporting period, the Hotline received 13,976 contacts. This resulted in opening 546 cases. The OIG reviewed 170 (31 percent) of these and referred the remaining 376 cases to VA program offices for review.

Output

- During the reporting period, Hotline staff closed 513 cases, of which 166 (32 percent) contained substantiated allegations. We wrote 82 letters responding to inquiries received from Members of the Senate and House of Representatives.

Outcome

- VA managers imposed 40 administrative sanctions against employees and took 81 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled almost $960,000.

Veterans Health Administration

Quality of Patient Care

The responses to Hotline inquiries by VA management officials indicated that 45 allegations regarding deficiencies in the quality of patient care provided by individual facilities were found to have merit and required corrective action. Examples follow.

- A VHA review substantiated allegations that five VA patients were delayed in receiving organ transplants at an affiliated university, in violation of uniform transplant network guidelines and policies. The Hotline received anonymous allegations that university patients who ranked below veteran patients were receiving liver transplants ahead of VA patients, without adequate explanation for the denials. The VHA review confirmed that one of the five patients was denied a liver on six occasions, with inaccurate refusal codes entered by the affiliate for all denials. Three of the other VA patients were denied organs on multiple occasions with similarly inaccurate refusal codes. For example, refusal codes indicated a patient was not within acceptable weight or serological standards, when the patient was within both standards. In one instance, the patient was recorded as unavailable when he was in the local VA hospital. Due to limited access to records from the affiliate, the review could not definitely ascertain the specific reasons for all denials. The review found that VA personnel complied with all VA and transplant network policies and procedures concerning allocations of transplant organs. Furthermore, VA personnel had not entered or approved refusal codes for declined organs for VA patients. On more than one occasion when organs were transplanted into university patients with lower transplant list scores, the VA transplant surgeons were not informed of the availability of donor organs. As a result of this review, the VAMC has applied for and received an independent charter for kidney and liver transplantation, has hired a transplant surgeon, and has an agreement with the United Network of Organ Sharing to notify a VA surgeon every time a liver or kidney becomes available for VA-listed transplant patients.

- A VHA review found that nursing staff had been illegally restraining patients with wrist restraints without a doctor's order and were not making appropriate entries in patient medical records when a physician ordered restraints. Consequently, supervisors have counseled the nursing staff involved, and quality control and monitoring measures have been implemented by management.

- A VHA peer review of a patient's psychiatric care determined his physician might have exercised questionable judgment in abruptly terminating the patient's psychotropic medications. The physician did so because he had concerns about the patient's elevated liver enzyme levels, but the review noted the enzyme levels were not unusual in this patient, who had a history of alcohol abuse and high cholesterol. The veteran was assigned to a new psychiatrist.

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 board of investigation concluded that an employee, while engaged in an intimate relationship with a non-employee, provided him with her network logon codes, allowing him to remotely access her VA computer and review e-mails in her VA Microsoft Outlook account. The facility information security officer determined that no sensitive medical records had been accessed. The employee received a reprimand for failure to safeguard confidential material.

- A VHA review confirmed that an employee misused a Government vehicle, used his Government travel credit card for dinner at a local restaurant while not on travel, and consumed alcoholic beverages on Government property. The employee's credit card has been suspended. Further personnel action is under review.

- A VHA review confirmed a complainant's allegations that two employees at a VAMC used their VA computers to access and use various unauthorized Internet sites, disregarding the needs and presence of patients seeking their services. Additionally, the review determined that another employee treated patients with contempt, spoke condescendingly to patients, and yelled at them when they were merely seeking information on eligibility concerns. All parties involved, to include their first line supervisor, received written counseling. One employee received a reprimand.

- A VHA review confirmed that a VA employee falsified her employment application by stating she was an American citizen when, in fact, she is a citizen of Surinam. Management is taking action to remove the employee from Federal service.

Time and Attendance

The responses to Hotline inquiries by management officials indicate that 14 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 confirmed that an employee used leave without pay to work at another job outside of the VA with his supervisor's knowledge. Disciplinary action was proposed.

Fiscal Controls

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

- A VHA review found that several vendors threatened to discontinue providing service to the medical center if they continued to receive late payments for services rendered. Management has eliminated the backlog and processed the claims. The review also found that the resource manager routinely moved money between fund control points without the knowledge of the service lines. Resource management and other service lines were not tracking day-to-day expenses, causing the inability of other service lines to track day-to-day spending. A process was put into place to

ensure service line notification when movement of funds occurred. Resource management will complete fund control point reconciliation. Service lines have been given access to the fund distribution control point listing and the accounting history on Veterans Health Information Systems and Technology Architecture.

Patient Safety

The responses to Hotline inquiries by management officials indicate that nine allegations of patient safety deficiencies at individual VA facilities were found to have merit and required corrective action. Examples follow.

- A VHA review found that a cystoscope that was used on 40 patients during a 7-month period was not being disinfected and processed according to manufacturer's recommendations. As a result, these 40 patients were mailed a letter that outlined the problem and were asked to make an appointment for follow-up if indicated. Patients who called were scheduled for evaluation and treatment.

- A VHA review determined that although newly-purchased ventilators initially performed well, as time passed, they exhibited evidence of unreliability and failure. Despite numerous attempts to repair and upgrade computer software, chronic unreliability persisted. Eventually the company provided rental replacement ventilators. When it became apparent that the ventilators would continue to be unreliable and unsuitable to the needs of the patient population, a decision was made to remove them permanently from service.

- A VHA review concluded that a home health contractor failed to comply with the requirement to service ventilator patients and responded inappropriately to a request. As a result, a cure notice was issued to the vendor, which requires the problem be "cured" by a deadline or the Government will terminate the contract for default. The vendor has since assigned additional registered respiratory therapists in the service area and assured VA that they intend to fulfill their contractual obligations. VA management is monitoring the vendor's performance.

Government Equipment and Supplies

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

- A VHA review of vehicle use at a VAMC found significant lapses in the administration of the program, including incomplete trip tickets, inadequate audits, and discrepancies in mileage reports compared to actual mileage. Chiefs of affected services admonished those employees involved. Additionally, the director ordered the facility compliance officer to review procedures regulating use of Government vehicles with all section chiefs and the associate director to recommend strategies to tighten controls.

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. An example follows.

- A VHA review substantiated the allegation of abuse of transit subsidy benefits by two VA employees. As a result, one employee voluntarily surrendered her bus pass. Management issued the second employee an official letter of counseling.

Privacy Issues/Health Insurance Portability and Accountability Act

The responses to Hotline inquiries by management officials indicate that four allegations involving violations of privacy and the new Act by employees at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow.

- A VHA review found that a veteran employee received copies of his medical records directly from his physician without going through the proper procedures of signing a release of information form. Management reviewed the procedures with care providers.

- A VHA review substantiated the allegation that documents containing sensitive patient information were improperly disposed. The information security officer discussed with the staff on duty the proper procedures for disposing of sensitive patient information. Management recommended all nursing staff receive a refresher training course on their roles and responsibility for properly disposing of sensitive patient information.

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 VHA review found there were systemic problems in the treatment of a patient who had pending criminal proceedings. As a result of the Hotline inquiry, a station policy is being developed giving guidance on admission and discharge of a patient involved in criminal proceedings. The existing policy on management of disturbed behavior is being revised to clarify the roles of all participants in any disturbance situation, including police officers. All pertinent staff will be given in-service training in order to recognize relevant court documents used in patient admissions and discharges when legal proceedings are involved. The psychiatry service chief has conducted an extensive review of one physician's cases to assess appropriateness of care and documentation practices. Appropriate disciplinary action is being taken.

- A VHA review concluded that a physician refused to fill out encounter forms for procedures, coding, and billing charges. He felt the requirement was clerical in nature, burdensome, and took away from his time to care for patients. This potentially might have caused the facility to lose thousands of dollars. Consequently, the surgical service has automated the procedure, with specialty clinics and general surgeons accepting the computer template encounter form. Additionally, the physician has agreed to begin using the

template, acknowledging that the number of patients he will see may need to be reduced in order to compensate for the time involved in completing the forms.

- A VHA review determined that due to the merging of two facilities and moving to a service-line structure, the peer review process for the social work staff was not formally maintained. As a result, a task group with representatives from both campuses was charged with developing a formal peer review process. Additionally, management reminded the staff about the importance of adhering to policies and procedures regarding confidentiality of patient information.

Veterans Benefits Administration

Receipt of VA Benefits

The responses to Hotline inquiries by management officials indicate that 20 allegations involving improprieties in the receipt of VA benefits were found to have merit and required corrective action. Examples follow.

- A VBA review determined a veteran's benefits should be reduced to 10 percent, which also included the loss of individual unemployability benefits and eligibility to receive dependents' educational assistance. Projected savings to the Government is $507,078.

- A VBA field examination and follow-up physical examination revealed that a veteran who claimed to be unable to work because of a painful back condition was still agile enough to climb trees, bend backward from the waist to install equipment, and walk briskly. The VARO has proposed terminating the veteran's rating of unemployability, resulting in a savings to VA of $332,883.

- A VBA review confirmed a veteran failed to notify VA of his incarceration, creating an overpayment of $34,810.

- A VBA review of a veteran's claim folder based on a Hotline inquiry determined that he failed to notify the VARO of his marriage annulment, causing an overpayment of $17,311. Corrective action was taken to remove the spouse and dependent children of the ex-spouse from the veteran's award.

- A VBA review confirmed that a veteran's guardian failed to keep the veteran apprised on a regular basis of all financial activities affecting his account. As a result of a meeting with the concerned parties, the guardian agreed to provide regular accounting of the veteran's financial activities.

Ethical Improprieties

The following violation of ethical conduct standards was found to have merit and required corrective action.

- A VA regional counsel review substantiated the allegation of violations of ethical conduct standards by two VARO employees. One VARO employee borrowed money from some of VHA's compensated work therapy program employees at the same facility. The other VARO employee had program employees get lunch for her and move her personal vehicle. As a result, management will be taking disciplinary action against the two employees.

Facilities and Services

The responses to Hotline inquiries by VA management officials indicated that 12 allegations regarding deficiencies with facilities or the services provided by individual VA facilities were found to have merit and required corrective action. An example follows.

- A VBA review of a veteran's records found that VARO employees had provided incorrect information in two of three e-mail responses regarding the start of the veteran's compensation payments as he completed a recoupment schedule. Management discussed the errors with the employees and supervisors of the responding teams. Additionally, an audit of the recoupment showed the veteran actually had a balance of $272 owing on his separation pay. This sum was withheld from his compensation.

National Cemetery Administration

Facilities and Services

The responses to Hotline inquiries by VA management officials indicated that one allegation regarding deficiencies with facilities or the services was found to have merit.

- An NCA review determined that the ashes of a decedent veteran's spouse were disinterred without appropriate consent from the immediate next-of-kin and released to an unauthorized family member who re-interred them outside of the United States. Management took appropriate administrative actions against staff involved.

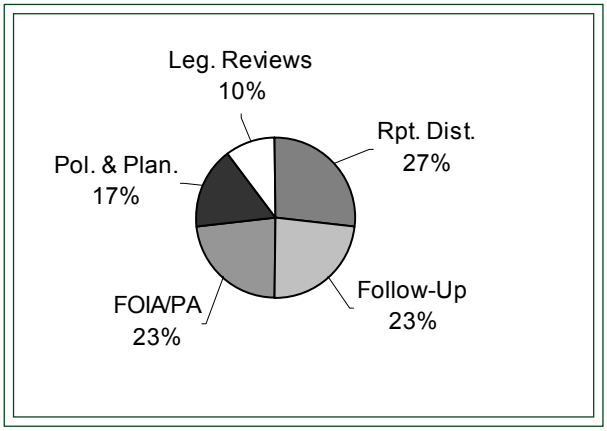
II. OPERATIONAL SUPPORT DIVISION

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 / Privacy Act requests; conducting policy review and development; strategic, operational, and performance planning; providing electronic report distribution; and overseeing Inspector General reporting requirements.

Resources

This Division has 10 FTE assigned with the following allocation.



Overall Performance

Follow Up on OIG Reports

Operational Support is responsible for obtaining implementation actions on previously issued audits, inspections, and reviews with over $2.04 billion of actual or potential monetary benefits as of March 31, 2004.

The Division maintains the centralized follow-up system that provides oversight, monitoring, and tracking of all OIG recommendations through both resolution and implementation. Resolution and implementation actions are monitored to ensure that disagreements between OIG and VA management are resolved promptly and that corrective actions are implemented by VA management officials. VA's Deputy Secretary, as the Department's audit resolution official, resolves any disagreements about recommendations.

After obtaining information that showed management officials had fully implemented corrective actions, Operational Support closed 89 reports and 395 recommendations with a monetary benefit of $807 million during this period. As of March 31, 2004, VA had 89 open OIG reports with 329 unimplemented recommendations.

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

Operational Support processes all OIG FOIA and PA requests from Congress, veterans, veterans service organizations, VA employees, news media, law firms, contractors, complainants, the general public, and subjects of investigations. In addition, we process official requests for information and documents from other Federal Departments and agencies, such as the Office of Special Counsel and the Department of Justice. These requests require the review and possible redacting of OIG hotline, healthcare inspection, criminal and administrative investigation, contract audit, and internal audit reports and files. Operational Support also processes 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 172 requests under the FOIA and PA and released 229 audit, investigative, and other OIG reports. Information was totally denied in 2 requests and partially withheld in 91 requests, because release would constitute an unwarranted invasion of personal privacy, interfere with enforcement proceedings, disclose the identity of confidential sources, disclose internal Departmental matters, or was specifically exempt from disclosure by statute. During this period, all FOIA cases received a written response within 20 workdays, as required. There are no requests pending over 6 months.

Electronic Report Distribution

The President's electronic Government initiatives, as described at http://www.whitehouse.gov/omb/egov/, aim to put Government at citizens' and employees' fingertips, making it more responsive and cost-effective. In keeping with this effort, electronic report distribution is an initiative to distribute OIG reports through a link to the OIG Web page. Individuals on the distribution list receive a short e-mail describing the report, with a link directly to the report.

We believe this distribution method provides many advantages. It is fast and efficient, avoiding the cost and delays involved in producing large numbers of paper copies and the time problems of security screening of mail deliveries. It greatly reduces the need to print paper copies. This approach also places OIG reports on our Web page as soon as they are issued.

We began using this method to distribute our CAP review reports in October 2003. During this reporting period, a total of 23 CAP reports, 3 CAP summary reports, and 1 non-CAP report were released electronically. We will expand it to include other OIG reports and information in the following months.

Review and Impact of Legislation and Regulations

Operational Support coordinated concurrences on 33 legislative, 47 regulatory, and 91 administrative proposals from the Congress, OMB, and VA. The OIG commented and made recommendations concerning the impact of the legislation and regulations on economy and efficiency in the administration of programs and operations or the prevention and detection of fraud and abuse.

III. INFORMATION TECHNOLOGY AND DATA ANALYSIS DIVISION

Mission Statement

Promote OIG organizational effectiveness and efficiency by ensuring the accessibility, usability, reliability 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 electronic databases.

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

Resources

The Division has 22 FTE allocated in Washington, Austin, and Chicago.

Overall Performance

Master Case Index (MCI)

During this reporting period, the MCI application has continued to expand in support of the OIG mission. Within MCI, the fugitive felon system now contains over 13,000 warrants. We are currently in the process of allowing intranet web access to the application in order to provide a mechanism for direct VHA and VBA status updates. New features within MCI include a searchable contact form for Hotline, and a property and weapons assignment tracking system for Investigations.

Internet and Electronic FOIA

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 1.5 million times by more than 125,000 visitors. The most popular reports were downloaded over 143,000 times, providing both timely access to OIG customers and cost avoidance in the reduced number of reports printed and mailed. OIG publications and vacancy announcements accounted for over 305,000 downloads from our Websites.
We worked directly with OIG's Operational Support Division in launching the OIG electronic report distribution initiative. This initiative showed an immediate benefit with an almost 200 percent increase in the number of downloads of our most popular reports (over 95,000 more downloads).

We posted the frequently requested report, *Administrative Investigation, Use of Government Funds, Travel, Personnel, Impartiality, and Management Issues, Research and Development Office, VHA*; and the report, *Interim Report - Patient Care and Administrative Issues at VAMC Bay Pines, FL,* in our electronic reading room in compliance with the Electronic Freedom of Information Act. We posted 37 CAP reports, 5 audit reports, 38 press releases, and other OIG publications on the Websites.

Information Management, Security, and Coordination

We provided hands-on training on the OIG's data encryption software to OIG investigators and health care inspectors. We successfully implemented a new initiative to provide live tele-training on our encryption software to OIG staff across the country, which decreased travel costs and increased both training participation and usage of encryption to protect sensitive data. We addressed information assurance threats that affected OIG IT resources, providing the OIG additional protection behind VA's information security infrastructure.

Statistical Support and IT Training

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

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

DATA ANALYSIS SECTION

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

Part-time Physician Time and Attendance Follow-Up

An unannounced follow-up review was conducted by VA OIG teams simultaneously at 15 medical facilities. An earlier review found an inordinate number of part-time physicians could not be located in a medical center despite being scheduled for work at specified times. DAS staff provided information related to approved work schedules and leave as a support for the teams. They focused on the 58 physicians who were not on duty to determine if leave had been pre-approved, whether tour changes had been properly scheduled, and to examine patient activity scheduling related to the individual physicians.

Fugitive Felon Matches

As a continuation of the computer match of VA records to state and Federal files, the DAS matched an additional 1.2 million felony warrant records from the National Crime Information Center, as well as from the States of New York, Tennessee and Washington. These felony records were matched with the more than 11 million records contained in the VA system files to produce 14,953 matched records in this reporting period.

Data Mining to Detect Potential Fraud in VA Computer Systems

The DAS took a proactive approach to finding and reporting fraud by developing computer profiles that reflect the known procedures used to defraud the VA. An updated run of the death match program resulted in an additional 1,575 referrals to the Office of Investigations.

Combined Assessment Program Reviews

The DAS provided technical support and data for 30 CAP health care reviews focusing on the quality, efficiency, and effectiveness of medical services provided to veterans. The DAS also provided support to nine CAP reviews on VA benefits, which focused on the delivery of monetary benefits to veterans and their dependents. A combined total of over 367 data extracts and reports were produced in support of this activity.

Assistance to Other Agencies

The DAS provided assistance on requests for VA information from the Department of Justice, SSA, and California Department of Justice. The information provided to these agencies was useful in criminal investigations.

IV. FINANCIAL AND ADMINISTRATIVE SUPPORT DIVISION

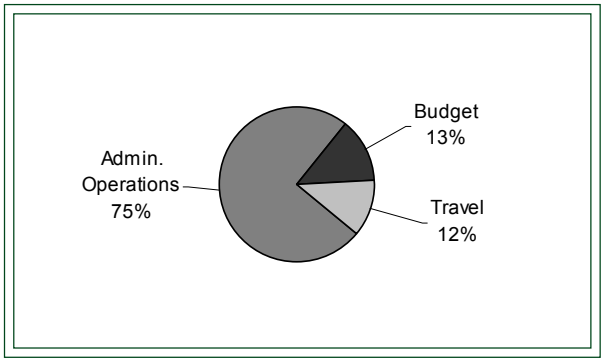
Mission Statement

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

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

Resources

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



Overall Performance

Budget

The staff assisted in the preparation of the FY 2005 budget submission and materials for associated hearings with VA and the Office of Management and Budget.

Travel

By the nature of our work, OIG personnel travel almost continuously. As a result, we processed 1,569 temporary duty travel and 25 permanent change of station vouchers.

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 furniture and equipment procurement. In addition, we processed 192 procurement actions and reviewed and approved monthly the 90 statements received from the OIG's credit cardholders under the Government's purchase card program.

V. HUMAN RESOURCES MANAGEMENT DIVISION

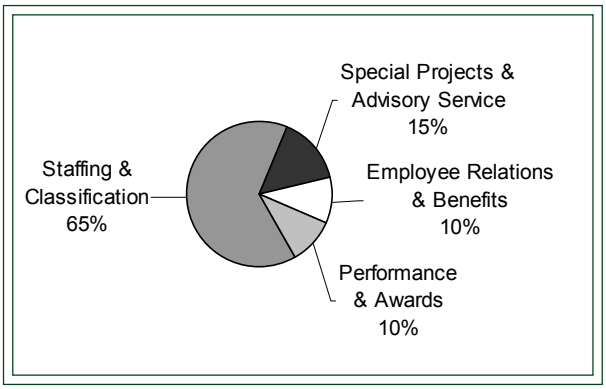
Mission Statement

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

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

Resources

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



Overall Performance

Human Resources Management

During this period, 46 new employees joined the OIG workforce and 21 departed. The current on-board strength is at its highest in OIG history with 405 employees in authorized positions and 24 employees in positions that are reimbursed by the Department. The staff processed 105 recruitment and placement actions, processed 55 awards, enrolled 22 employees in advanced management development classes, and collected 482 hours of donated leave for OIG employees experiencing medical emergencies.

Fifteen college students are working part-time in our field offices and headquarters in a variety of occupational disciplines under the OIG Student Career Experience Program. Students in this program receive developmental assignments and training in their career fields, and are eligible for permanent placement upon graduation. Our first students will graduate this May.

OTHER SIGNIFICANT OIG ACTIVITIES

President's Council on Integrity and Efficiency

- The OIG Financial Audits 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.

- The Director, Audit Operational Support Division, represented VA OIG in a PCIE workgroup to revise the external quality control review guides used by all Federal agencies to ensure compliance with the U.S. General Accounting Office's generally accepted Government auditing standards.

OIG Management Presentations

Leadership VA 2003 Program

- The Inspector General made a presentation on the work of the OIG to the Leadership VA Class of 2003. This program is VA's premier leadership development program.

VISN Directors Conference

- The Deputy AIGs for Audit and Healthcare Inspections made a presentation on the FY 2004 CAP schedule at the VHA VISN Director's meeting.

Office of Acquisition and Materiel Management's Acquisition Forums

- The Counselor to the IG and OIG representatives from the Contract Review and Evaluation Division made two presentations to VA contracting personnel. The presentations covered various aspects of contracting with affiliates for health care resources.

VISN 6 Management

- The Counselor to the IG and an OIG representative from the Contract Review and Evaluation Division made a presentation to VISN 6 facility directors, associate directors, chiefs of staff, and regional counsel. The presentation covered various aspects of contracting with affiliates for health care resources.

American Bar Association Public Law 102-585 Conference

- A representative from the OIG's Contract Review and Evaluation Division presented to industry on the effect of Public Law provisions on VA awarded Federal Supply Schedule pharmaceutical contracts. The American Bar Association hosted the 1-day conference.

VHA Chief Logistics Officers Conference

- The Director, Veterans Benefits and Healthcare Audit Division, gave a presentation on VAMC supply procurement practices and the contract hierarchy at the conference.

VHA Radiology Teleconference

- The Director, Audit Planning Division, gave a presentation to VHA radiologists on issues emerging from CAP reviews relating to the award and administration of radiology contracts.

VA Acquisition Managers Symposium

- The Director, Veterans Benefits and Healthcare Audit Division, gave a presentation on OIG evaluations and VA procurement issues. Also an audit manager from the Bedford Audit Operations Division made presentations on contract issues identified during CAP reviews and OIG's evaluation of the purchase card program.

System-Wide Ongoing Assessment and Review Strategy Consultant Training Conference

- The Directors of the Dallas Audit Operations Division and Healthcare Inspections Regional Office made a presentation on CAP reviews and recent findings to VHA employees training as consultants.

Washington Chapter of the Association of Certified Fraud Examiners

- The OIG Human Resources Director addressed the chapter on career development and advancement in the Government.

Data Integrity Board

- The Deputy AIG for Audit served on the VA board that reviews and approves agency computer matching proposals.

Awards and Special Thanks

Secretary's Exceptional Service Award

- We said good-bye to Michael G. Sullivan, the former Deputy Inspector General, upon his retirement after a distinguished 35-year Federal career. Secretary Principi presented Mr. Sullivan with the Department's highest award, the Secretary's Exceptional Service Award, in recognition of his leadership and dedicated service to our Nation's veterans at a retirement ceremony held on March 30, 2004.

Secretary's Meritorious Service Awards

- Michael Slachta, Jr., retired from the position of Assistant Inspector General for Audit on January 2, 2004. Secretary Principi recognized Mr. Slachta with the Secretary's Meritorious Service Award for his noteworthy career achievements spanning 32 years at the VA.

- After 32 years of service with the VA, Alanson J. Schweitzer retired from the position of Assistant Inspector General for Healthcare Inspections on December 27, 2003. Secretary Principi recognized Mr. Schweitzer's significant career achievements with the Secretary's Meritorious Service Award.

PCIE 2003 Awards Ceremony - October 16, 2003

- The "June Gibbs Brown Career Achievement Award" was presented to Michael Slachta, Jr., in recognition of Mr. Slachta's leadership of the VA OIG Office of Audit.

- An "Award for Excellence - Multiple Disciplines" was presented to 29 staff members in ten OIG audit, healthcare inspections, investigations, and IT offices in recognition of their diligent, collaborative efforts in conducting the sanitation and CAP follow-up review at VAMC Kansas City that resulted in improved quality medical care for veterans. Team members included Michael Slachta, Jr., Michael Staley, Robert Zabel, Larry Reinkemeyer, Joseph Janasz, Jr., Kenneth Myers, Carla Reid, Lynn Scheffner, Dennis Capps, James Garrison, Robin Frazier, Henry Mendala, Oscar Williams, Marcia Schumacher, Linda DeLong, Patricia Christ, Verena Briley-Hudson, Frederick Marchand, Paula Chapman, Sheila Cooley, Michele Eskridge, Leslie Rogers, Gregory Billingsley, John Metzler, Mary Lopez, Gilberto Melendez, Judy Shelly, Steven Wise, and Kelli Kemper.

- An "Award for Excellence - Audit" was presented to nine staff members from the Kansas City Audit Operations Division and the Austin Data Analysis Section in recognition of their efforts to improve the integrity, efficiency, and effectiveness of VHA's management of part-time physician time and attendance. Team members included William Withrow, Larry Reinkemeyer, Joseph Janasz, Jr., Kenneth Myers, Carla Reid, Dennis Capps, Henry Mendala, Oscar Williams, and Gilberto Melendez.

- An "Award for Excellence - Audit" was presented to six staff members from the Contract Review and Evaluation Division in recognition of their consistent efforts resulting in significant cost recoveries, reducing contract costs, identifying areas of contract vulnerabilities, and ensuring compliance with applicable laws and regulations that resulted in achieving $17.5 million in monetary benefits for the 12-month period. Team members included Marci Anderson, Michael Grivnovics, Lacy Jamison, James P. O'Neill, Tina Robinson, and Brenda Lindsey.

- An "Award for Excellence - Investigations" was presented to two staff members from the Office of Investigations in recognition of their tireless and outstanding investigative efforts during the investigation of Edward Lee Daily. Team members were the Nashville Resident Agent in Charge, Michael Keen; and the Director, OIG Questioned Document Forensic Laboratory, Stephen Fortenberry.

Clarksburg and Harrison County, WV Sherlock Holmes Award

Washington Resident Agency special agents Patrick McCormack and Jeffrey Stachowiak were recognized by the law enforcement community of Clarksburg and Harrison County, West Virginia, by being awarded the Sherlock Holmes Award for their roles in a long term, and highly successful drug investigation at the Louis B. Johnson VA Medical Center, Clarksburg, WV. They identified several VAMC employees and contractors who were involved in a series of gambling, theft, and other employee misconduct that had an effect on patient care and employee morale. In addition, they identified VAMC personnel who were engaged in dealing and/or brokering the sale of controlled substances on VA property while on duty. Previous attempts by the law enforcement community to penetrating the illegal operations proved unsuccessful prior to Special Agents McCormack's and Stachowiak's involvement. All subjects either pled guilty or were found guilty at trial.

Thank You from American Airlines

- Dorothy Duncan, R.N., Healthcare Inspector, Dallas Healthcare Inspections Regional Office, received a formal "Thank You" from American Airlines for the assistance provided to a stricken passenger on October 26, 2003, aboard flight 4410 which operated from Chicago to Portland. The letter stated: "We are all grateful that you were on board and freely offered your medical expertise when it was needed most. Without a doubt, you helped improve a difficult situation."

American Organization of Nurse Executive

- Verena Briley-Hudson, Director, Chicago Regional Office of Healthcare Inspections, was elected to the American Organization of Nurse Executives Board of Director's Nominating Committee, Region 5. In this special leadership role, she will represent nurse leaders who are shaping the future of and improving health care.

American Pharmacists Association

- Dr. Wilma Wong, Associate Director, Los Angeles Regional Office of Healthcare Inspections, received the association's Distinguished Achievement Award in Hospital and Institutional Practice award in recognition of her quarter-century commitment to VA's health care facilities and strong influence on the direction of pharmacy practice, which has affected policies on the national level. From her early days as a staff clinical pharmacist to her current management position, Dr. Wong has never lost sight of her primary mission as a pharmacist: providing the best pharmaceutical care, especially for veterans.

Letters of Appreciation

- Verena Briley-Hudson, Director, Chicago Regional Office of Healthcare Inspections, received letters of appreciation and congratulations from the President of the American Hospital Association and VHA's Chief Nursing Officer for her energetic commitment and contributions to excellence and leadership in nursing.

OIG Congressional Testimony

- In January 2004, the Assistant Inspector General for Healthcare Inspections, accompanied by the Director, Atlanta Regional Office of Healthcare Inspections, testified before the House Committee on Veterans' Affairs. The testimony presented the results of our evaluation of the VHA Community Nursing Home Program and the Homemaker and Home Health Aide 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				
03-02420-6 10/14/03	Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center Salisbury, NC	$136,550	$136,550	
03-02278-8 10/29/03	Combined Assessment Program Review of the Coatesville VA Medical Center Coatesville, PA	$162,198	$162,198	
03-02290-12 11/4/03	Combined Assessment Program Review of the Grand Junction VA Medical Center Grand Junction, CO			
03-02374-17 11/7/03	Combined Assessment Program Review of the Muskogee VA Medical Center Muskogee, OK	$155,436	$155,436	
03-01948-18 11/10/03	Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System			
03-02446-23 11/13/03	Combined Assessment Program Review of the G.V. (Sonny) Montgomery VA Medical Center Jackson, MS	$51,500	$51,500	
03-02612-27 11/21/03	Combined Assessment Program Review of the Sheridan VA Medical Center Sheridan, WY	$73,674	$73,674	
03-02067-29 11/21/03	Combined Assessment Program Review of the VA Medical Center Tomah, WI	$110,716	$110,716	
03-02191-47 12/15/03	Combined Assessment Program Review of the VA Regional Office Buffalo, NY	$137,831	$137,831	
03-02029-45 12/19/03	Combined Assessment Program Review of the VA Medical/Regional Office Center Cheyenne, WY			
03-01357-61 1/12/04	Combined Assessment Program Review of the VA Medical Center Wilkes-Barre, PA	$68,599	$68,599	
03-02577-62 1/12/04	Combined Assessment Program Review of the Lebanon VA Medical Center Lebanon, PA			

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)				
04-00115-65 1/28/04	Combined Assessment Program Review of the VA Regional Office Columbia, SC	$44,294	$44,294	
03-02850-66 1/28/04	Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics White City, OR	$14,292	$14,292	
03-03136-69 1/28/04	Combined Assessment Program Review of the Louis A. Johnson VA Medical Center Clarksburg, WV			
03-03208-76 2/2/04	Combined Assessment Program Review of the James E. Van Zandt VA Medical Center Altoona, PA	$48,400	$48,400	
03-02725-93 2/27/04	Combined Assessment Program Review of the VA Regional Office Houston, TX	$230,551	$230,551	
03-02996-94 3/1/04	Combined Assessment Program Review of the VA Black Hills Health Care System			
03-02735-103 3/16/04	Combined Assessment Program Review of Veterans Health Administration Activities at the Robert J. Dole VA Medical and Regional Office Center Wichita, KS	$320,286	$320,286	
03-02735-104 3/16/04	Combined Assessment Program Review of Veterans Benefits Administration Activities at the Robert J. Dole VA Medical and Regional Office Center Wichita, KS	$96,853	$96,853	
03-03210-109 3/18/04	Combined Assessment Program Review of the VA Medical Center Salem, VA	$205,983	$205,983	
04-00059-110 3/18/04	Combined Assessment Program Review of the VA Medical Center St. Cloud, MN	$10,329	$10,329	
03-02906-116 3/22/04	Combined Assessment Program Review of the VA Regional Office San Diego, CA	$55,894	$55,894	
COMBINED ASSESSMENT PROGRAM SUMMARY REVIEWS				
04-00625-38 12/8/03	Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities October 2002 through September 2003			
04-00624-54 1/2/04	Summary Report of Combined Assessment Program Reviews at Veterans Benefits Administration Regional Offices October 2002 through September 2003			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use: OIG	Funds Recommended for Better Use: Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM SUMMARY REVIEWS (Cont'd)				
04-01010-111 3/18/04	Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities October 2003 through December 2003			
JOINT REVIEW				
04-01371-108 3/19/04	Interim Report - Patient Care and Administrative Issues at VA Medical Center Bay Pines, FL			
INTERNAL AUDITS				
03-01237-21 11/14/03	Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2003 and 2002			
02-03210-43 12/9/03	Audit of the Department of Veterans Affairs Information Security Program			
03-02159-52 12/19/03	Report of the Audit of the Department of Veterans Affairs' Franchise Fund Consolidated Financial Statements for Fiscal Years 2003 and 2002			
03-02520-85 2/18/04	Follow-up of the Veterans Health Administration's Part-Time Physician Time and Attendance Audit			
04-00897-113 3/17/04	Attestation of the Department of Veterans Affairs Detailed Accounting Submission			
02-01481-118 3/31/04	Audit of VA Medical Center Procurement of Medical, Prosthetic, and Miscellaneous Operating Supplies	$1,397,500,000	*$0	
OTHER OFFICE OF AUDIT REVIEWS				
03-01356-10 10/24/03	Review of Department of Veterans Affairs Fiscal Year 2002 Special Disabilities Capacity Report			
02-02759-20 11/10/03	Evaluation of Allegations of Irregularities in Acquiring a Telecommunication System for Veterans Integrated Service Network 15			
03-01950-31 11/25/03	Evaluation of Alleged Compensation and Pension Data Integrity Problems at VA Regional Office Salt Lake City, UT			

* VHA stated they could not provide an estimated monetary benefit pending their review of the volume and cost of supplies purchased in FY 2003, including 50 products reviewed by the OIG. This review, to be completed by June 2004, will provide useful data for determining the effectiveness of current measures to enhance procurement practices.

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)				
03-00396-36 12/1/03	Evaluation of Medical Insurance Billing Practices at VA Medical Centers Bedford and Northampton, MA			
03-02970-55 1/9/04	Evaluation of the Department of Veterans Affairs' Installation of the Microsoft Blaster Worm Patch			
03-00810-89 2/25/04	Evaluation of Allegations Regarding the Anesthesiology Residency Program at the VA Greater Los Angeles Healthcare System			
CONTRACT PREAWARD REVIEWS **				
03-01974-5 10/10/03	Review of Federal Supply Schedule Proposal Submitted by Buffalo Supply, Inc., Under Solicitation Number 797-FSS-99-0025			
03-02762-9 10/22/03	Review of Federal Supply Schedule Proposal Submitted by 3M Pharmaceuticals Under Solicitation Number M5-Q50A-03			
03-02494-11 10/27/03	Review of Federal Supply Schedule Proposal Submitted by Chiron Corporation Under Solicitation Number M5-Q50A-03	$1,899		
03-02493-13 10/29/03	Review of Proposal Submitted by the University of Miami Under Solicitation Number RFP 546-38-03 for Anesthesiology Services at the Department of Veterans Affairs Medical Center Miami, FL	$709,555		
03-02761-14 10/29/03	Review of Proposal Submitted by the University of Utah Hospitals & Clinics Under Solicitation Number 660-023-03 for Heart Transplants and LVAD/RVAD Services for the Department of Veterans Affairs Salt Lake City Health Care System	$649,200		
03-03023-19 11/5/03	Review of Federal Supply Schedule Proposal Submitted by Sanofi-Synthelobo, Inc., Under Solicitation Number M5-Q50A-03			
04-00133-22 11/7/03	Review of Proposal Submitted by the University of Kansas Medical Center Under Contract Number V225P(589)0849 for Otolaryngology Services for the Department of Veterans Affairs Medical Center Kansas City, MO			

** 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 PREAWARD REVIEWS (Cont'd)				
03-02748-25 11/13/03	Review of Federal Supply Schedule Proposal Submitted by Schering Corporation Under Solicitation Number M5-Q50A-03	$90,126,165		
03-02987-28 11/17/03	Review of Proposal Submitted by Northwestern Memorial Hospital Under Solicitation Number RFP 69D-078-03 for Liver Transplantation Services for the VA Chicago Healthcare System			
03-03003-32 11/24/03	Review of Proposal Submitted by the University of Medicine & Dentistry of New Jersey Under Solicitation Number RFP 10N3-070-03 for Radiology Services at the Department of Veterans Affairs New Jersey Health Care System	$399,429		
04-00369-33 11/24/03	Review of Proposal Submitted by Stanford School of Medicine Under Solicitation Number RFP 261-0079-03 for Vascular Physician Services at the VA Palo Alto Health Care System	$462,514		
03-02795-34 11/24/03	Review of Federal Supply Schedule Proposal Submitted by Kos Pharmaceuticals, Inc., Under Solicitation Number M5-Q50A-03	$8,469,166		
03-02853-40 12/3/03	Review of Federal Supply Schedule Proposal Submitted by Centocor, Inc., Under Solicitation Number M5-Q50A-03			
03-03088-41 12/4/03	Review of Federal Supply Schedule Proposal Submitted by Boehringer Ingelheim Pharmaceuticals, Inc., Under Solicitation Number M5-Q50A-03			
04-00051-42 12/4/03	Review of Federal Supply Schedule Proposal Submitted by Intermune, Inc., Under Solicitation Number M5-Q50A-03			
03-02425-44 12/8/03	Review of Federal Supply Schedule Proposal Submitted by Novartis Ophthalmics, Inc., for Pharmaceuticals Under Solicitation Number M5-Q50A-03	$47,936		
04-00291-46 12/9/03	Review of Proposal Submitted by Medical College of Virginia Physicians Under Solicitation Number 652-049-02 for Radiation Oncology Services at VAMC Richmond, VA	$423,880		

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT PREAWARD REVIEWS (Cont'd)				
04-00368-49 12/15/03	Review of Proposal Submitted by Stanford School of Medicine Under Solicitation Number RFP 261-0238-02 for Cardiothoracic Physician Services at the VA Palo Alto Health Care System	$403,087		
03-03076-50 12/22/03	Review of Federal Supply Schedule Proposal Submitted by Par Pharmaceutical, Inc., Under Solicitation Number M5-Q50A-03	$2,280,185		
03-01809-57 12/30/03	Review of Proposal Submitted by Johnson & Johnson Health Care Systems Inc., on Behalf of Ortho-McNeil Pharmaceutical, Inc., Under Solicitation Number M5-Q50A-03	$103,867		
04-00064-58 12/30/03	Review of Federal Supply Schedule Proposal Submitted by ZLB Bioplasma Under Solicitation Number M5-Q50A-03			
04-00199-59 1/5/04	Review of Federal Supply Schedule Proposal Submitted by Elan Pharmaceuticals Under Solicitation Number M5-Q50A-03			
03-02208-60 1/6/04	Review of Federal Supply Schedule Proposal Submitted by Eisai Inc., Under Solicitation Number M5-Q50A-03	$69,436,556		
04-00065-63 1/7/04	Review of Proposal Submitted by Indiana University Under Solicitation Number 583-63-02 for Allergist Services at Richard L. Roudebush VA Medical Center	$14,620		
03-03020-67 1/13/04	Review of Federal Supply Schedule Proposal Submitted by Bayer Pharma Corporation Under Solicitation Number M5-Q50A-03			
04-00570-71 1/16/04	Review of Proposal Submitted by Gilead Sciences, Inc., Under Solicitation Number M5-Q50A-03			
03-02816-72 1/16/04	Review of Proposal Submitted by Duke University Health Systems, Inc., Under Solicitation Number RFP 246-03-00160 for Anesthesiology Services at the Department of Veterans Affairs Medical Center, Durham, NC	$1,074,040		
03-03150-74 1/22/04	Review of Federal Supply Schedule Proposal Submitted by American Pharmaceutical Partners, Inc., Under Solicitation Number M5-Q50A-03	$6,489,197		

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT PREAWARD REVIEWS (Cont'd)				
03-03166-75 1/30/04	Review of Federal Supply Schedule Proposal Submitted by Alcon Laboratories, Inc., Under Solicitation Number M5-Q50A-03	$80,888		
03-03022-77 1/30/04	Review of Federal Supply Schedule Proposal Submitted by Wyeth Pharmaceuticals Under Solicitation Number M5-Q50A-03	$72,617,155		
03-02384-78 2/2/04	Review of Federal Supply Schedule Proposal Submitted by Bayer Pharma Corporation, Biological Products, Under Solicitation Number M5-Q50A-03			
03-02760-80 2/4/04	Review of Proposal Submitted by the University of Pittsburgh Physicians Under Solicitation Number 646-62-03 for Critical Care Medicine Physician Services at the Department of Veterans Affairs Pittsburgh Health Care System			
04-00070-82 2/5/04	Review of Federal Supply Schedule Proposal Submitted by Bedford Laboratories Under Solicitation Number M5-Q50A-03	$821,720		
04-00576-83 2/12/04	Review of Philips Medical Systems' Direct Delivery Pricing Proposal for Ultrasound Imaging Systems Under Solicitation Number M6-Q5-03			
04-00575-87 2/17/04	Review of General Electric Medical Systems, Inc.'s, Direct Delivery Pricing Proposal for Ultrasound Imaging Systems Under Solicitation Number M6-Q5-03	$2,464,056		
04-00188-91 2/20/04	Review of Federal Supply Schedule Proposal Submitted by Schwarz Pharma, Inc., Under Solicitation Number M5-Q50A-03	$1,094,371		
04-00431-90 2/24/04	Review of Proposal Submitted by the University of Pennsylvania Health System Under RFP Number 642-02-04 for Interim Cardiac Surgery Services for the Department of Veterans Affairs Medical Center Philadelphia, PA			
03-02320-99 3/1/04	Review of Proposal Submitted by Stanford School of Medicine Under Solicitation Number RFP 261-0074-03 for Anesthesia Physician Services at the VA Palo Alto Health Care System	$341,115		

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT PREAWARD REVIEWS (Cont'd)				
03-03055-97 3/1/04	Review of Federal Supply Schedule Proposal Submitted by Bristol-Myers Squibb Pharma Company Under Solicitation Number M5-Q50A-03			
03-02318-100 3/2/04	Review of Proposal Submitted by University of California, San Francisco, Under Solicitation Number RFP 261-0142-03 for Anesthesia Physician Services at the VA Medical Center San Francisco	$66,765		
03-02749-98 3/4/04	Review of Federal Supply Schedule Proposal Submitted by Smithkline Beecham Corporation d/b/a Glaxosmithkline Under Solicitation Number M5-Q50A-03	$261,930,409		
04-00581-105 3/9/04	Review of Proposal Submitted by the University of Minnesota Physicians Under Solicitation Number 618-68-04 for Cardiac/Thoracic Surgical Procedures at the VA Medical Center, Minneapolis, MN	$506,512		
04-00324-112 3/16/04	Review of Proposal Submitted by University Medical Associates of Nebraska Under Solicitation Number 636-0029-03 for Anesthesiology Services at VA Nebraska Western Iowa Health Care System Omaha Division	$564,134		
04-00568-117 3/25/04	Review of Proposal Submitted by University of Utah Under Solicitation Number 660-72-03 for Hematology/Oncology Services at VA Salt Lake City Health Care System	$921,556		
CONTRACT POSTAWARD REVIEWS				
03-02544-3 10/7/03	Review of Amgen, Inc.'s, Self-Audit of Federal Ceiling Price Errors Under Federal Supply Schedule Contract V797P-5109x			$24,661
03-02673-4 10/9/03	Review of Gynetics, Inc.'s, Billings Under Federal Supply Schedule Contract Number V797P-5355x			$2,731
02-00813-24 11/13/03	Review of Mylan Pharmaceuticals, Incorporated's Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Number V797P-5328x			
03-01235-26 11/13/03	Post-Award Review of C.R. Bard, Inc., Electrophysiology Division's Federal Supply Schedule Contract, V797P-3618k			$183,043

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT POSTAWARD REVIEWS (Cont'd)				
04-00189-35 11/24/03	Review of the Billings and Final Payment Due From Dicut, Inc., on the Patient Medical Information Printing and Mailing Blanket Purchase Agreement Number VANAC049A1NIC-03-001			$100,535
00-02849-37 11/25/03	Settlement Agreement Pharmaceutical Manufacturer			$465,371
03-02969-51 12/18/03	Review of Modification Request From the Sewing Source, Inc., to Contract Number V797P-4437a	$531,852		
03-01234-53 12/22/03	Review of C.R. Bard, Inc.'s, Billings Under Federal Supply Schedule Contract Number V797P-3349k			$28,991
04-00292-56 12/30/03	Review of Self-Audit Performed by Women's Capital Corporation for Public Law 102-585, Section 603 Overcharges			$15,833
00-00228-88 2/2/04	Settlement Agreement Life Technologies, Inc.			$14,291,261
04-01264-84 2/17/04	Verification of Celltech Americas, Inc.'s, Self-Audit Under Federal Supply Schedule Contract Number V797P-5197X			$2,570
04-01169-96 2/27/04	Review of Upsher-Smith Laboratories, Inc.'s, Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract V797P-5263x			$76,345
HEALTHCARE INSPECTIONS				
02-03260-1 10/6/03	Healthcare Inspection, Patient Care Issues, VA Medical Center Philadelphia, PA			
03-01915-2 10/7/03	Healthcare Inspection, Quality of Care Issues, VA Long Beach Healthcare System Long Beach, CA			
03-01644-15 10/29/03	Healthcare Inspection, Patient Care Incident, VA Medical Center Dayton, OH			
03-02160-16 11/4/03	Healthcare Inspection, Patient Care, Communication, and Privacy Issues, Overton Brooks VA Medical Center Shreveport, LA			
03-02799-30 11/24/03	Healthcare Inspection, Patient Care and Infection Control Issues, VA New Jersey Health Care System East Orange, NJ			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
HEALTHCARE INSPECTIONS (Cont'd)				
03-00391-39 12/3/03	Healthcare Inspection, Medical Care Foster Home Program, Central Arkansas Veterans Healthcare System Little Rock, AR			
02-00124-48 12/18/03	Healthcare Inspection, Evaluation of Veterans Health Administration Homemaker and Home Health Aide Program	$10,700,000	***$0	
03-01526-64 1/12/04	Healthcare Inspection, Alleged Medical Treatment Issues, Houston VA Medical Center Houston, TX			
03-01914-68 1/14/04	Healthcare Inspection, Anesthesia Management and Patient Care Issues, New Mexico VA Healthcare System Albuquerque, NM			
03-01423-70 1/16/04	Healthcare Inspection, Quality of Care Issues, Iowa City VA Medical Center			
03-02849-81 2/6/04	Healthcare Inspection, Patient Care Issues, VA Greater Los Angeles Healthcare System Los Angeles, CA			
03-02167-101 3/10/04	Healthcare Inspection, Contract Nursing Home Patient Care Issues, VA Pittsburgh Healthcare System, University Drive Division Pittsburgh, PA			
03-01744-102 3/10/04	Healthcare Inspection, Patient Care Issues, Samuel S. Stratton Department of Veterans Affairs Medical Center Albany, NY			
03-02306-107 3/15/04	Healthcare Inspection, Quality of Care, Patient Information Security, and Environment of Care Issues Edward Hines, Jr. VA Hospital Hines, IL			
03-01743-114 3/18/04	Healthcare Inspection, Survey of Efforts to Safeguard VA Potable and Waste Water Systems			
03-02149-221 3/31/04	Healthcare Inspection, Drug Overdose, Department of Veterans Affairs Medical Center Hampton, VA			

***VHA stated they could not provide an estimated monetary benefit.

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use: OIG	Funds Recommended for Better Use: Management	Questioned Costs
ADMINISTRATIVE INVESTIGATIONS				
03-02130-7 10/22/03	Administrative Investigation, Impartiality Issue, VA Medical Center Tomah, WI			
03-00966-73 1/16/04	Administrative Investigation, Use of Nonprofit Research Corporation Funds, VA San Diego Healthcare System San Diego, CA			
03-00815-79 2/4/04	Administrative Investigation, Solicitation of Gifts and Other Ethics Issues, VA Medical Center Bay Pines, FL			
03-01120-86 2/18/04	Administrative Investigation, Contract and Employee Retreat Expenditure Issues, Financial Assistance Office, Veterans Health Administration			$823
03-02467-95 2/27/04	Administrative Investigation, Position Classification Issue, VA Medical Center Albuquerque, NM			
03-01975-106 3/11/04	Administrative Investigation, Property Misuse and Supervisory Oversight Issues, Emergency Management Strategic Healthcare Group, Martinsburg, WV			
03-03053-115 3/22/04	Administrative Investigation, Use of Government Funds, Travel, Personnel, Impartiality, and Management Issues, Research and Development Office, Veterans Health Administration			$9,737
TOTAL	**118 Reports**	**$1,933,155,215**	**$1,923,386**	**$15,201,901**

APPENDIX B

STATUS OF OIG REPORTS UNIMPLEMENTED FOR OVER 1 YEAR

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

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

The following chart lists the total number of unimplemented OIG reports and recommendations by organization. It also provides the total number of unimplemented reports and recommendations issued over 1 year ago (March 31, 2003, and earlier).

Unimplemented OIG Reports and Recommendations				
VA Office	Total		Issued 3/31/03, and Earlier	
	Repts	Recoms	Repts	Recoms
A&MM	45	99	0	0
VHA	34	173	4	12
VBA	5	19	1	4
I&T	3	21	0	0
VHA/S&LE	1	15	1	15
VHA/I&T	1	2	1	2
Total	**89**	**329**	**7**	**33**

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

The OIG is particularly concerned with one report on VHA operations (issued in 1997) and one report on VBA operations (issued in 2000) with recommendations that still remain open. The following information provides a summary of reports over a year old with open recommendations.

Veterans Health Administration

Unimplemented Recommendations and Status

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

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

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

Status: The VHA Chief Consultant for Geriatrics and Extended Care has proposed guidelines and benchmark rates that has been set forth in a draft home health and hospice care reimbursement handbook. The handbook was drafted in September 2003; however, it has not received VHA staff concurrence. No planned completion date is available.

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

Recommendations:

1. The Under Secretary for Health should improve Medical Care Collection Fund program operations by ensuring that VA medical facilities use the preregistration software as required.

Status: The VHA Chief Business Office has submitted a project request for an enhancement to the VHA diagnostic measures to include a new national report on the use of the pre-registration software. The addition of this report to the diagnostic measures Website will allow VHA to ensure that facilities are using the software. The planned completion date for report deployment is July 2004.

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Report: *Healthcare Inspection, Patient Care Issues, Department of Veterans Affairs Hudson Valley Health Care System, Franklin Delano Roosevelt Campus Montrose, New York. 02-02374-08, 10/18/02*

Recommendation:

1. The VISN Director should ensure that the VA Hudson Valley Health Care System Director brings the Franklin Delano Roosevelt campus Residential Care Program into compliance with VHA policy by ensuring that all VA-sponsored homes meet all State and local requirements.

Status: As of March 31, 2004, there are 66 veterans residing in 10 unlicensed community residential care homes, as compared to 182 veterans in 28 unlicensed homes on October 1, 2002. The VA Hudson Valley Health Care System continues facilitating the licensure process of the homes by working closely with the VA Central Office program office (VHA Chief Consultant for Geriatrics and Extended Care); the New York State Department of Health, Office of Child and Family Services; and the VA sponsored homes. The homes are inspected regularly and provisions are in place for immediately relocating the veterans from a home if a home fails to meet inspection requirements. The veterans will be relocated should a home fail to demonstrate a good faith effort in the licensure process. The planned completion date is April 2005.

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Report: *Healthcare Inspection, Evaluation of the VHA's Contract Community Nursing Home Program 02-00972-44, 12/31/02*

Recommendations: The Under Secretary for Health needs to ensure that:

1. VHA medical facility managers devote the necessary resources to adequately administer the Contract Nursing Home (CNH) program.
2. Critical aspects of the new VHA policy are discussed with senior managers, CNH review teams, and other applicable quality management program employees using education and training mediums.
3. VHA medical facility managers emphasize the need for CNH review teams to access and critically analyze external reports of incidents of patient abuse, neglect, and exploitation, and to increase their efforts to collaborate with state ombudsman officials.
4. Clarify whether the new VHA policy intended the responsibilities of CNH oversight committees to be extended to CNH review teams or some other committee.
5. Contracting officers strengthen the contracting process by requiring CNHs to produce current state licenses, Department of Health and Human Services Center for Medicaid and Medicare Services certifications, assurances of the clinical competency and backgrounds of CNH clinical employees, Center for Medicaid and Medicare Services or state minimum standards for staffing levels to provide direct nursing care to veterans on a daily basis, and submissions of routine performance improvement data.
6. CNH review teams are reminded to critically evaluate and mitigate the risks associated with routinely transporting veterans between CNHs and VA medical facilities.
7. Managers integrate CNH activities into medical facility quality management programs and review performance data to monitor bedsores, medication errors, falls, and other treatment quality indicators that may warrant their attention.
8. Coordinate efforts with the Under Secretary for Benefits to determine how VHA CNH managers and VBA fiduciary and field examination employees can most effectively complement each other and share information such as medical record competency notes, on-line survey certification and reporting data, and VBA reports of adverse conditions, to protect the financial interests of veterans receiving health care and VA-derived benefits.

Status: As of March 31, 2004, 8 of 11 recommendations remain unimplemented pending actions by the VHA Chief Consultant for Geriatrics and Extended Care. VHA needs to finalize and publish CNH Handbook 1143.2, "VHA Community Nursing Home Oversight Procedures." In addition, VHA needs to finalize new performance indicators; schedule training audio broadcasts; upgrade the Website from the prototype to a finalized site; demonstrate that community health nurses and social workers are visiting veterans in CNHs at the recommended frequency and gathering the recommended information; complete the

guidance, appropriate Website links, and special broadcast on new exclusionary criteria related to neglect and abuse; and finalize implementation plan/coordinated efforts on how VHA CNH and VBA fiduciary and field examination employees can most effectively complement each other and share information. Completion of the CNH Website links is expected in April 2004. No planned completion dates for the other actions are available.

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

Unimplemented Recommendations and Status

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

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

1. Redefine and strengthen security and access requirements and procedures for safeguarding high-risk agents and materials used in VA facilities, such as the agents on the Centers for Disease Control and Prevention Select Agents List, other biological agents, toxic chemicals, and certain pharmaceuticals that might be targeted for use by terrorists.
2. Improve personnel access controls and reduce vulnerabilities to theft of selected agents by implementing measures such as the consistent use of photo identification badges with expiration dates, installation of electronically controlled entry points to and from sensitive areas, and use of key-card systems, video surveillance, and/or biometric systems.
3. Review documents related to VA leased-space to others for research use (e.g., to an affiliated university) to ensure that VA's agreements define security responsibilities and limitations.
4. Clarify VA's accountability and responsibilities for actions of non-VA persons supervising VA or non-VA research in VA facilities or in VA space leased to other institutions.
5. Strengthen controls for authorizing and procuring high-risk materials and agents including biological agents, and ensure that inventory, transfer, and validated destruction policies and procedures account for biological agents and chemicals at all times. Additionally, procedures should outline appropriate requirements for the use of witnesses to verify transfer and destruction processes.
6. Require managers to transfer, dispose of, or establish delimiting dates on select agents no longer in use and stored in research and clinical laboratories.
7. Reevaluate the extent of compliance with radiation safety and handling/delivery procedures, particularly vendor deliveries after regular working hours and on weekends. In addition, facility managers should require contractors and vendors to provide evidence that background and legal histories on their employees are checked before they are allowed to access sensitive VA areas.
8. Strengthen human resource management controls and procedures to consistently verify or update non-citizens' legal residence or employment status while working in VA facilities or on VA matters, including students and contractors.
9. Reevaluate the adequacy of security clearance level requirements for employees who could have access to or work with highly sensitive agents and materials.

10. Take action on non-citizen employees without valid legal status and notify appropriate legal authorities.
11. Take action on any noncitizens with access to VHA research and clinical laboratories if they are considered "restricted persons" according to the USA PATRIOT Act.
12. Ensure clearance and checkout procedures extend to employees without compensation and contract employees.
13. Issue guidance to revise local disaster plans to include provisions for responding to terrorist activities.
14. Direct managers at all facilities to perform vulnerability assessments of their physical research and clinical laboratories and consistently implement security measures.
15. Provide researchers and other appropriate personnel necessary training on security issues, including security of high-risk and sensitive agents, and procedures to forward requests for research articles through their managers and the facility Freedom of Information Act officer.

Status: This report requires action by VHA and the Office of Security and Law Enforcement (S&LE), part of the Office of Policy, Planning, and Preparedness. The Under Secretary for Health and the Assistant Secretary for Policy and Planning were requested by the VA Deputy Secretary to issue a joint report by September 30, 2002, certifying that all the recommendations had been completed. However, as of March 31, 2003, 15 of 16 recommendations continue to remain unimplemented.

VHA's Office of Research and Development plans on systematically reviewing all field research sites over the next 3 years. In November 2002, VHA issued Directive 2002-075, "Control of Hazardous Materials in VA Research Laboratories," and a revision should be published by the end of April 2004. VHA's clinical laboratory managers "are expected to operate in accordance with the recommendations" of VHA's Biohazardous Materials Task Force as well as an issued joint memorandum. The memorandum was an interim measure to immediately address laboratory safety and security and to apply already existing Department physical security standards. Based on that memorandum, S&LE inspectors began reviewing VHA clinical and research laboratory security as part of routine, on-site program inspections. VHA also published an Emergency Management Guidebook with requirements to include security of sensitive and critical locations as part of facilities' hazard vulnerability assessments. The VHA Office of Patient Care Services is developing a directive for the clinical Biosafety Level 2 and 3 laboratories and it should be published by the end of April 2004. In the interim, all clinical laboratories were reminded of the necessity for complying with existing accreditation and regulatory requirements and letters of instruction regarding the handling of select agents. In addition, all VHA certifications will be consolidated and provided to the OIG after all directives and handbooks are published and implemented.

VA's S&LE office is revising a draft of VA Directive and Handbook 0730, "Security and Law Enforcement" and VA Directive 0710, "Personnel Suitability and Security Program." No planned completion date is available for these three documents.

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Joint (Veterans Health Administration and Office of Information and Technology)

Unimplemented Recommendations and Status

Report: *Healthcare Inspection, Evaluation of VHA Medical Record Security and Privacy Practices, 01-01968-41, 12/24/2002*

Recommendations: The Assistant Secretary for Information and Technology, in conjunction with the Under Secretary for Health, issue additional guidance requiring that VHA managers:

1. Position computer monitors such that patient information is not visible to unauthorized persons in the area and install computer privacy screens for those monitors that cannot be adequately repositioned.
2. Appoint full-time or primary-duty information security officers and ensure that they have the necessary technical skills in automated information systems.

Status: This report requires action by VHA and the Office of Information and Technology.

1. All VISNs and VAMCs have been directed to review positioning of computer terminals and make physical adjustments where possible to ensure the information on the terminal is not visible to unauthorized persons, or install privacy screens on those terminals that cannot be adequately repositioned. In turn, VISNs must provide a consolidated report to VHA. The planned completion date is June 30, 2004.
2. The VA Office of Information and Technology has incorporated staff comments into a revised draft directive and handbook that includes the responsibilities to appoint full-time or primary-duty information security officers. The expected concurrence and approval is by August 2004.

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Veterans Benefits Administration

Unimplemented Recommendations and Status

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

Recommendations: The Under Secretary for Benefits should:

1. Establish a positive control Benefits Delivery Network (BDN) system edit keyed to employee identification number that ensures employee claims are adjudicated only at the assigned regional office of jurisdiction and prevents employees from adjudicating matters involving fellow employees and veterans service officers at their home office.
2. Establish a BDN system field for third-person authorization and a control to prevent release of payments greater than $15,000 without the third-person authorization.
3. Determine the feasibility of direct input and storage of rating decisions in BDN.
4. Take steps necessary to make use of Social Security Numbers (SSNs) as employee identification numbers, and tie BDN access to SSNs.

Status: 1 and 2. As the Modern Award Processing system is designed, this control will be incorporated. Beta testing of the system began in March 2004. This control will be implemented in the final stages of deployment that is scheduled for completion in December 2005.

3. A new version of the Rating Board Automation 2000 application was deployed to all VAROs. In March 2004, VAROs were notified that they had 60 days to review the new installation and validate that all outstanding defects that impeded the 100 percent utilization of the new application have been eliminated. Upon conclusion of this period of validation, VBA will determine the feasibility and schedule for the retirement of the old application.
4. VBA implemented a change to the BDN security screen to include SSNs and the BDN user's full name. The SSN was added to VBA regional office user and VHA user accounts that have processing capability. VBA considers this recommendation closed. The OIG is in the process of verifying that the intent of the recommendation has been met.

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APPENDIX C

INSPECTOR GENERAL ACT REPORTING REQUIREMENTS

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

IG Act References	Reporting Requirement	Page
Section 4 (a) (2)	*Review of legislation and regulations*	*64*
Section 5 (a) (1)	*Significant problems, abuses, and deficiencies*	*1-68*
Section 5 (a) (2)	*Recommendations with respect to significant problems, abuses, and deficiencies*	*1-68*
Section 5 (a) (3)	*Prior significant recommendations on which corrective action has not been completed*	*85 (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*	*94 (App. C)*
Section 5 (a) (6)	*List of audit reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use*	*73 to 83 (App. A)*
Section 5 (a) (7)	*Summary of each particularly significant report*	*i to vii*
Section 5 (a) (8)	*Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports*	*95 (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*	*96 (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 of reporting period*	*94 (App. C)*
Section 5 (a) (11)	*Significant revised management decisions*	*94 (App. C)*
Section 5 (a) (12)	*Significant management decisions with which the Inspector General is indisagreement*	*94 (App. C)*
Section 5 (a) (13)	*Information described under section 5(b) of the Federal Financial Management Improvement Act of 1996 (Public Law 104-208)*	*94 (App. C)*

Prior Significant Recommendations Without Corrective Action and Significant Management Decisions

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

Obtaining Required Information or Assistance

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

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

The IG Act requires the OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with the requirements of Public Law 104-208. The OIG has reported in our *Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2003 and 2002* (Report Number 03-01237-21, Issued 11/14/03), that corrective action dates in the VA remediation plan are all in the future.

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

The IG Act requires a summary of audit reports issued before this reporting period for which no management decision was made by the end of the reporting period. There were no internal OIG reports unresolved for over 6 months. However, there were six contract review reports unresolved because a contracting officer decision has not been made for over 6 months. These contract review reports were issued before the start of this semiannual reporting period and will be closed after the OIG receives the contracting officer price negotiation memorandum following contract awards.

Statistical Tables 1 and 2 Showing Number of Unresolved Reports

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

TABLE 1 - RESOLUTION STATUS OF REPORTS WITH QUESTIONED COSTS

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

RESOLUTION STATUS	NUMBER OF REPORTS	QUESTIONED COSTS (in Millions)
No management decision by 9/30/03	0	$0
Issued during reporting period	12	$15.2
Total Inventory This Period	**12**	**$15.2**
Management decision during reporting period		
Disallowed costs (agreed to by management)	12	$15.2
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Period	**12**	**$15.2**
Total Carried Over to Next Period	**0**	**$0**

Definitions:

- **Questioned Costs**

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

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

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

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

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

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

RESOLUTION STATUS	NUMBER OF REPORTS	RECOMMENDED FUNDS TO BE PUT TO BETTER USE (IN MILLIONS)
No management decision by 9/30/03	15	$17.4
Issued during reporting period	47	$1,933.1
Total inventory this period	**62**	$1,950.5
Mangement decisions during reporting period		
Agreed to by management	27	$1,414.9
Not agreed to by management	3	$5.3
Total Management Decisions This Period	**30**	**$1,420.2**
Total Carried Over to Next Period	**32**	**$530.3**

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 D

OIG OPERATIONS PHONE LIST

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APPENDIX E

GLOSSARY

A&MM	Acquisition and Materiel Management
AARP	American Association of Retired Persons
BDN	Benefits Delivery Network
BPA	Blanket Purchase Agreement
CAP	Combined Assessment Program
CNH	Contract Nursing Home
CoreFLS	Core Financial and Logistics System
DAS	Data Analysis Section
EP	End Products
FBI	Federal Bureau of Investigation
FOIA/PA	Freedom of Information Act/Privacy Act
FSS	Federal Supply Schedule
FTE	Full Time Equivalent
FY	Fiscal Year
HUD	Department of Housing and Urban Development
I&T	Office of Information and Technology
IG	Inspector General
IT	Information Technology
MCCF	Medical Care Collection Fund
MCI	Master Case Index
NCA	National Cemetery Administration
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
OMB	Office of Management and Budget
PTSD	Post-Traumatic Stress Disorder
S&LE	Office of Security and Law Enforcement
SPD	Supply Processing and Distribution
SSA	Social Security Administration
SSN	Social Security Number
U.S.	United States
UCLA	University of California, Los Angeles
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VAMROC	Veterans Affairs Medical and Regional Office Center
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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VA OIG, Washington, DC

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Department of Veterans Affairs
Office of Inspector General
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