



# **Office of Inspector General**

## **Semiannual Report to Congress**

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**April 1, 1998 – September 30, 1998**



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## FOREWORD

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I am pleased to submit the semiannual report on the activities of the Office of Inspector General (OIG) for the period ended September 30, 1998. This semiannual report is being issued in accordance with the provisions of the Inspector General Act of 1978, as amended.

OIG oversight of major Department of Veterans Affairs' (VA) programs resulted in systemic improvements and increased efficiencies in areas of medical care, procurement, financial management, and facilities management. OIG audits, investigations and other reviews identified over \$406 million in monetary benefits, for an OIG return on investment of \$23 for every dollar expended. A particularly noteworthy accomplishment was an audit of VA's Workers Compensation program, which identified opportunities to reduce long-term program costs by \$247 million. Additional OIG accomplishments during the period included 54 criminal convictions and 88 administrative actions, foremost of which were cases involving health care and benefits fraud and employee misconduct.

VA, the second largest Department in the Federal government, operates the largest health care system in the United States. The OIG Office of Healthcare Inspections continues to focus on quality of care issues to include Veterans Health Administration's (VHA's) deployment of Quality Management staff and the implementation of the Patient Safety Improvement Policy. Through the Quality Program Assistance review process, our healthcare inspectors conducted proactive reviews of essential aspects of VHA clinical operations and patient treatment processes and made recommendations for improvement.

Please note that we changed the format for this semiannual report to make it more user friendly. Accomplishments are discussed by OIG component, i.e., Office of Investigations, Office of Audit, Office of Healthcare Inspections, and Office of Departmental Reviews and Management Support. Within each section, we present results by VA organizational unit, e.g., Veterans Health Administration, Veterans Benefits Administration, and so forth.

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

*(Original signed by:)*  
RICHARD J. GRIFFIN  
Inspector General

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## HIGHLIGHTS OF OIG OPERATIONS

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This semiannual report highlights the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for the 6-month period ended September 30, 1998. Following are the statistical highlights of OIG activities and some of the major accomplishments during the reporting period by OIG component.

<u>DOLLAR IMPACT</u>	<u>Dollars in Millions</u>
Funds Put to Better Use.....	\$387.6
Dollar Recoveries .....	\$15.0
Fines, Penalties, Restitutions, and Civil Judgments .....	\$4.0
<b><u>RETURN ON INVESTMENT</u></b>	
Dollar Impact (\$406.6M) / Cost of OIG Operations (\$17.4M).....	23 : 1
<b><u>OTHER IMPACT</u></b>	
Indictments .....	61
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Opened .....	128
Closed.....	99
Hotline Activities	
Contacts.....	7,609
Cases Opened.....	439
Cases Closed .....	497

### OFFICE OF INVESTIGATIONS

During the semiannual period, criminal investigative priority was given to cases of patient abuse, instances where incapacitated veterans fall victim to unscrupulous fiduciaries, public corruption, and major thefts. Immediate response to these types of allegations is absolutely essential. To this end, we are able to draw upon the varied skills of the entire OIG staff. As examples, patient abuse investigations were usually conducted with the assistance of OIG health care professionals and major theft/embezzlement investigations utilized the expertise of OIG audit staff. This combined multidisciplinary approach resulted in successful judicial actions. These cases demonstrate that the OIG will take decisive action

against those who prey on veterans and will hold accountable those VA employees who disregard their public trust responsibilities. During the period, the Office of Investigations closed 99 investigations resulting in 115 judicial actions and over \$6 million returned or saved.

### Veterans Health Administration

The following are examples of investigations in which Veterans Health Administration (VHA) employees have been arrested for various illegal activities. (i) An individual employed in a VA pharmacy was convicted of theft after a VA OIG investigation found that he conspired to steal approximately \$150,000 in pharmaceuticals from the VA Medical Center (VAMC) for shipment to a commercial pharmacy. (ii) Two individuals employed at a VAMC were arrested after an investigation found that they were in possession of cocaine and crack cocaine, and sold the drugs to other employees and to undercover operatives on VAMC property. (iii) A husband and wife who worked at a VAMC pleaded guilty to charges of bank larceny after an investigation found that they executed a scheme to obtain credit cards in the names of patients at the VAMC. They fraudulently obtained the cards by using personal patient information and forging patient signatures, and then used the cards to obtain more than \$25,000 in cash and merchandise. (iv) An individual employed at a VA Outreach Center pleaded guilty to charges of workers' compensation fraud; mail fraud; and false statements. He allegedly suffered an on-the-job injury for which he received more than \$300,000 in workers' compensation benefits payments. The investigation found that he worked a variety of different jobs during the period he was collecting benefits. (v) A nurse at a VAMC was found guilty of making a telephone bomb threat to a facility in retaliation against co-workers who reported her as being involved in suspicious deaths there.

### Veterans Benefits Administration

The following investigations are examples of fraud relating to some of the benefits programs administered by VA. (i) An individual was convicted after trial on charges of equity skimming; mail fraud; bankruptcy fraud; and money laundering. The investigation found that he had fraudulently assumed more than 50 properties whose mortgages were guaranteed by VA or insured by the Department of Housing and Urban Development. He rented the homes but retained the rent proceeds rather than paying the lenders, causing the loans to go into default. (ii) Three VA employees were found guilty of conspiracy to defraud VA after an investigation found that they had participated in a scheme to embezzle over \$1 million from VA. In their capacities of providing assistance to veterans, they submitted false claims for medical expenses and demanded kickbacks from the veterans they supposedly served. (iii) An individual was sentenced to 6 months' home confinement, 5 years' probation, and ordered to pay over \$100,000 restitution after an investigation found that, over a 15-year period, he converted for his own use more than \$100,000 in Dependency and Indemnity Compensation benefits paid to his deceased mother. (iv) The U.S. Attorney's Office is continuing to obtain civil settlements from student veterans who received VA education benefits but did not attend scheduled college classes. Bribes were paid to faculty staff to ensure high grades would be given with no class attendance required. To date, 216 students have agreed to pay \$2,633,638 in restitution. Negotiations are continuing with additional students. Criminal proceedings against the college staff are pending.

### National Cemetery System

A Federal grand jury has returned an 11-count indictment against two individuals, the director of a VA national cemetery and a private contractor, who supplied sand from the cemetery to other contractors.

## **OFFICE OF AUDIT**

We planned audits and evaluations to focus on determining how programs can work better, while emphasizing improved service to veterans. As a consequence, the 20 program and financial audits and evaluation reports issued during this 6-month reporting period have had a significant and positive impact on VA program operations.

These reports made recommendations to enhance operations or correct deficient areas that contained \$370 million in monetary benefits. The Office of Audit had a return on investment ratio of \$46 in monetary benefits for every dollar spent.

### **Veterans Health Administration**

The following are examples of major health care related audits. (i) A report on the management of Pathology and Laboratory Medicine Service (PLMS) operations concluded that while PLMS was generally operated in a satisfactory manner, management needed to more closely monitor quality control testing, staffing, and send-out tests. We estimated that over \$2 million could be saved annually by increasing oversight of the cost of quality control testing. In addition, we found that opportunities exist for VHA to increase operational savings by an estimated \$32 million annually by taking advantage of its purchasing power to obtain chemistry tests at a lower cost. (ii) Our review of Medical Care Cost Recovery (MCCR) collection and billing practices concluded that VHA can enhance MCCR recoveries by \$83 million by using collection tools developed by the MCCR program office, and obtaining insurance data from veterans. (iii) As part of an ongoing national audit of VHA's Minor Construction and Nonrecurring Maintenance projects, we identified four construction projects that were not needed or could be reduced in scope, resulting in cost savings of approximately \$1.6 million.

### **Office of Management**

The audit of VA's Consolidated Financial Statements for the Fiscal Years 1997 and 1996 included a qualified opinion concerning balances for receivables, liabilities for loan guarantees, and resources payable to Treasury contained in VA's Statement of Financial Position, and the items in the Statements of Operations and Changes in Net Position; Cash Flows; and Budgetary Resources and Actual Expenses. In each of these areas, we were unable to satisfy ourselves as to the recorded balances in these accounts because of inadequate accounting records. Nor were we able to satisfy ourselves as to the balances by other auditing procedures.

### **Multiple Office Action**

An audit of VA's Workers' Compensation Program (WCP) found that opportunities exist to reduce WCP costs by about \$247 million, over the projected 18 year lifetime of claimants on the rolls, by conducting more effective case management to identify employees who can be brought back to work or who should be removed from WCP rolls.

## **OFFICE OF HEALTHCARE INSPECTIONS**

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

VHA has medical quality assurance procedures in place to detect a wide variety of medical errors, but it needs to consider employing additional statistical procedures that will allow clinical managers to quickly identify and correct subtle changes in clinical practices or behaviors that may result in unwanted clinical outcomes, before the resulting problems become too serious. OHI confirmed that a majority of hotline complaints are based on perceptions that VHA employees treated patients improperly, either personally or clinically, and that VHA managers need to emphasize the need for employees to treat patients and their family members as valued and important people.

### Program Reviews

We conducted three health care program reviews. (i) Our analysis of VHA inpatients depicted seriously ill individuals whose health care was complicated by impaired social support systems, and badly compromised nutrition status. These factors should be important to VHA planners and managers as they develop treatment planning and treatment access strategies in a health care system that is evolving to predominantly ambulatory care. (ii) Our analysis of substantiated health care hotline allegations provided VHA managers with information on what areas they need to emphasize for improvement in order to better treat VA patients. (iii) Our proposal of an alternate statistical methodology to track and trend quality management continuous monitoring information provided a way for VHA statisticians and program managers to detect and correct the causes of possibly unwanted behaviors or practices that may result in patient harm, earlier than most commonly used statistical methods.

### Quality Program Assistance Reviews

Our Quality Program Assistance (QPA) reviews at two VAMCs found that managers are working collaboratively to ensure that veterans have access to high quality, low cost health care. Employees generally support the changes, but the rapid pace and scope of changes are negatively affecting employee morale. Our review of the QPA process shows that VHA clinical managers and VAMC executive managers are generally supportive of the QPA's and feel that it adds value to their efforts to maintain high quality patient care.

### Patient Care Services

A patient care review concluded that attending and resident physicians rotated to other wards and teaching facilities so frequently that nursing employees, patients, and family members did not know who the specific responsible physician was in the event of an urgent medical situation.

## **OFFICE OF DEPARTMENTAL REVIEWS AND MANAGEMENT SUPPORT**

### Contract Review and Evaluation

Since 1993, the Division and OIG Counselor have worked closely with Office of Acquisition and Materiel Management (A&MM) officials and contracting officers, with Office of General Counsel attorneys, and with VHA Pharmacy Benefits Management to provide VA with a unified and coordinated approach to reviewing certain contracts and contracting practices, and recovering contractor overcharges. As a result of this approach, VA has witnessed a dramatic increase in dollar recoveries as well as a huge increase in companies voluntarily disclosing to VA that they have overcharged the Government. Audits completed by the Division during the period resulted in recoveries of \$14.3 million. This represents a \$31 return for every \$1 expended. Almost all of these recoveries have been returned to VA to fund

needed VA programs. Recommendations were also made to assist contracting officers in negotiating the best possible prices that may save VA an additional \$14.1 million.

### Hotline and Special Inquiries

The Hotline and Special Inquiries program provides an opportunity for employees, veterans, and other concerned citizens to report fraud, waste, abuse, and mismanagement. The identification and reporting of issues such as these are integral to the goal of improving the efficiency and effectiveness of the Federal Government. We are encouraged to find employees, veterans and other concerned citizens who are willing to report illegal or wasteful activities they have observed in order to improve Government operations. Because of their efforts during the semiannual period, the Hotline and Special Inquiries Division recorded 32 administrative sanctions against employees and 106 corrective actions taken by management to improve VA operations and activities. The reports issued by special inquiries staff concerned serious issues of misconduct against high ranking officials and other high profile matters, which received a great deal of interest from the U.S. Congress, VA Secretary, VA managers, media, and the general public. The Inspector General testified in May 1998 before the Subcommittee on Oversight and Investigations, House Veterans' Affairs Committee regarding one special inquiries report. In another request from the Subcommittee, we responded to numerous allegations of mismanagement, misconduct, poor clinical care practices, criminal activity, and administrative irregularities at one VA medical health care system. The subsequent report resulted in recommendations to take administrative actions against senior officials and supervisors, correct certain personnel violations, and improve patient care procedures, and administrative operations and activities.

### Followup on OIG Reports

The Followup, Policy, and Operational Support Division is responsible for obtaining implementation actions on audits, inspections, and reviews with over \$1 billion of actual or potential monetary benefits as of September 30, 1998. Of this amount \$795 million is resolved, but not yet realized as VA has agreed to implement the recommendations, but has not yet done so. In addition, \$248 million relates to unresolved reviews awaiting contract resolution by VA contracting officers. During this reporting period, the Division took action to close 75 reports issued in this and prior periods, with 242 recommendations and a monetary benefit of \$133 million, after obtaining information that showed management officials had fully implemented corrective actions.





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# VA AND OIG MISSION, ORGANIZATION, AND RESOURCES

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## The Department of Veterans Affairs (VA)

### Background

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

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

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

### Mission

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

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

### Organization

VA has 3 administrations that operate direct services to veterans:

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

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

- Management (Budget, Financial Management, Acquisition and Materiel Management (A&MM)),
- Information and Technology,
- Policy and Planning,
- Human Resources and Administration (Human Resources Management, Administration, Security and Law Enforcement, Equal Opportunity, and Resolution Management),
- Public and Intergovernmental Affairs, and
- Congressional Affairs.

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

### Resources

While most Americans know that VA exists, few have any idea of the size of this Department, which is the nation's second largest in terms of staffing. For FY 1998, VA had 207,066 employees and a \$43 billion budget.

There are an estimated 25.9 million living veterans and the provision of legislatively mandated services to them is a massive operation. To serve our nation's veterans, VA maintains facilities in every state of the union and the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Philippines.

Approximately 191,000 of VA's employees work in the health care system. Health care accounts for \$18 billion (approximately 42%) of VA's budget in FY 1998. VHA provides care to an average of 63,000 inpatients daily. During FY 1998, slightly more than 35 million episodes of care were provided to outpatients. There are 172 hospitals, 602 outpatient clinics, 132 nursing home units, and 40 domiciliaries.

Veterans benefits were funded at \$24 billion (almost 56%) in FY 1998. The 11,254 employees of VBA provide benefits to veterans and their families. Approximately 2.6 million veterans and their beneficiaries receive compensation benefits valued at over \$17 billion. Also over \$3 billion in pension benefits are provided to veterans and survivors. VA life insurance programs have 4.8 million policies in force with a face value of over \$469 billion. Almost 369,000 home loans were guaranteed, with a value of almost \$40 billion.

The National Cemetery System operates and maintains 115 cemeteries and had 1,328 employees in FY 1998. Operations of NCS and all of VA's burial benefits accounted for approximately \$199 million of VA's \$43 billion budget. There are almost 77,000 interments in VA cemeteries each year. Approximately 337,000 headstones and markers are provided for veterans and their eligible dependents in VA cemeteries, state veterans' cemeteries, and private cemeteries.

## **VA Office of Inspector General (OIG)**

### **Background**

VA's OIG was administratively established on January 1, 1978, to consolidate audit, investigation, and related operations into a cohesive, independent organization. In 1978, the Inspector General Act (Public Law 995-452) was enacted and established a statutory Inspector General (IG) in VA.

### **Role and Authority**

The Inspector General Act of 1978 states that the IG is responsible for: (1) conducting and supervising audits and investigations, (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect fraud and abuse in, the programs and operations of VA, and (3) keeping the Secretary and the Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action.

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

**Organization**

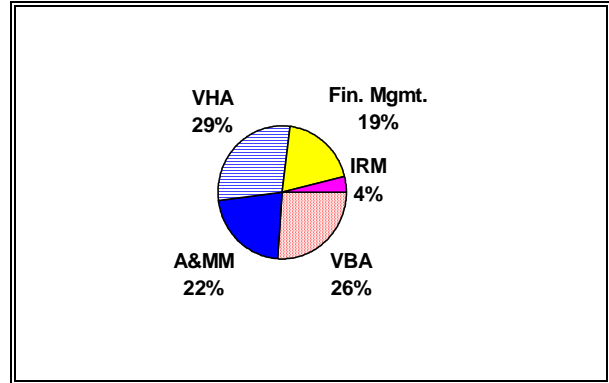
Allocated full time equivalent (FTE) for FY 1998 was as follows:

OFFICE	ALLOCATED FTE
Inspector General	4
Counselor	4
Investigations	80
Audit	170
Departmental Reviews and Management Support	* 45
Healthcare Inspections	20
<b>TOTAL</b>	<b>323</b>

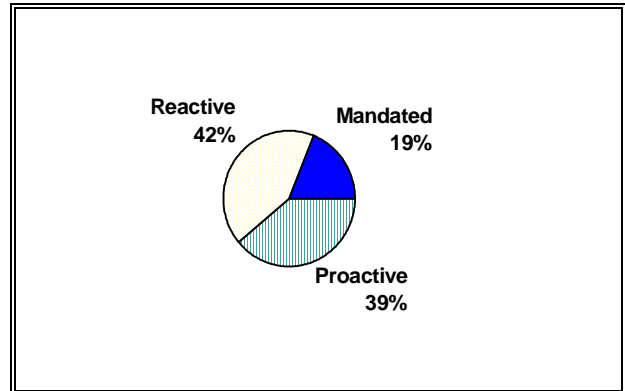
\* Does not include 23 reimbursable FTE.

FY 1998 funding for OIG operations was \$33.4 million, with \$31 million from appropriations and \$2.4 million through reimbursable agreements. Approximately 85 percent of the total funding was for personnel salaries and benefits, 5 percent for official travel, and the remaining 10 percent for all other operating expenses such as contractual services, rent, supplies, and equipment.

The percent of OIG resources, which have been devoted during this semiannual reporting period in VA's major organizational areas, are indicated in the following chart.



The following chart indicates percent of OIG resources which have been devoted to mandated, reactive, and proactive work.



**Mandated** work is required by law and the Office of Management and Budget; examples are our audits of VA's Consolidated Financial Statements, followup activities, and Freedom of Information Act information releases.

**Reactive** work is generated in response to requests for assistance received from external sources concerning allegations of fraud, waste, abuse, and mismanagement. Most of the work performed by the Offices of Investigations and Hotline and Special Inquiries is reactive.

**Proactive** work is self-initiated and focuses in areas where the OIG staff determines there are significant issues; healthcare inspections and audits fall into this category.

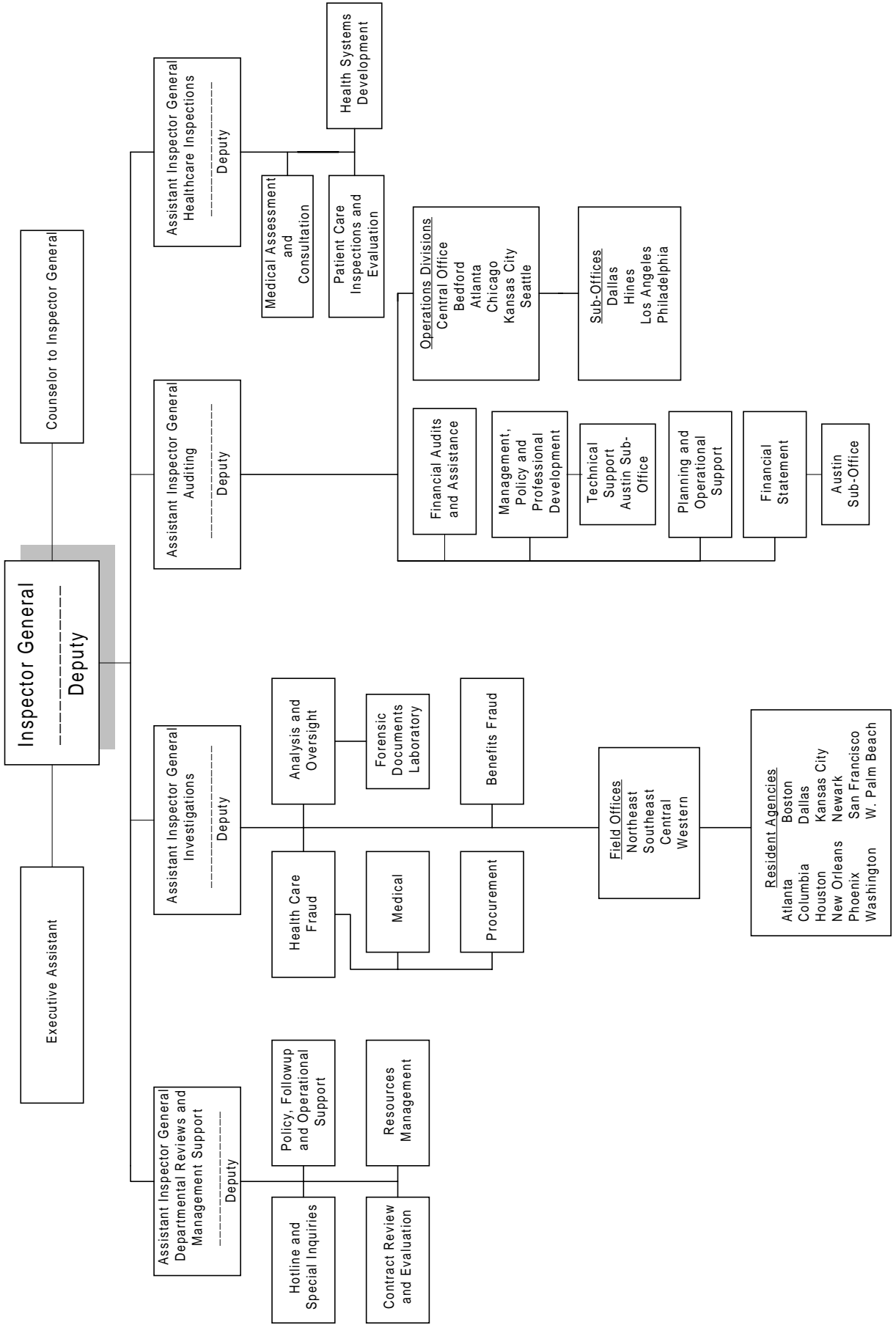
## OIG Mission Statement

*The OIG is dedicated to helping VA ensure that veterans and their families receive the care, support, and recognition they have received 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 audits, health care inspections, investigations, special inquiries, and contract reviews to promote economy, efficiency, and effectiveness in VA activities, and to detect and deter fraud, waste, abuse, and mismanagement. The OIG's oversight efforts emphasize the goals of the National Performance Review and the Government Performance and Results Act for creating a government that works better and costs less. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer driven and results oriented.*

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

DEPARTMENT OF VETERANS AFFAIRS  
OFFICE OF INSPECTOR GENERAL





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# OFFICE OF INVESTIGATIONS

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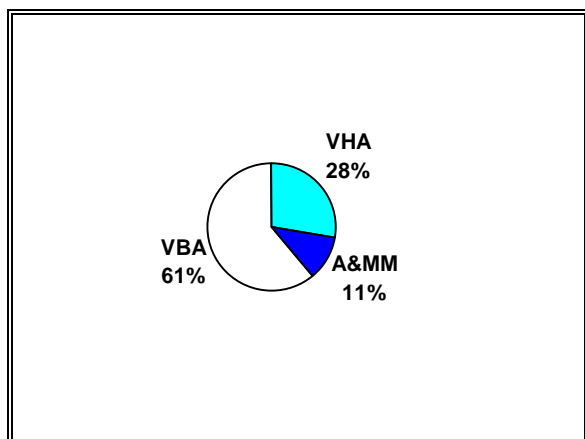
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## Mission Statement

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

## Resources

Office of Investigations was allocated 80 FTE for its headquarters and 16 field locations for FY 1998. These individuals were deployed in the following program areas:



## Overall Performance

### Output

- 99 investigations were closed during the reporting period.

### Outcome

- Indictments - 61
- Convictions - 54
- Monetary Benefits - \$6.1 million
- Administrative Sanctions - 56

## Cost Effectiveness

- The average cost of conducting the 99 closed investigations was \$11,354. Each investigation averaged a return of \$51,683, resulting in approximately \$4.60 returned for every \$1 spent.

## Timeliness

- Average work days from receipt of allegation to initiation of investigation averages 39 days against a goal of 45 days.
- Average work days from initiation of investigation to referral to an Assistant U.S. Attorney was 179 days which greatly exceeded our goal of 365 days.

## Customer Satisfaction

- Customer satisfaction survey forms were provided to each prosecutor upon referral of an investigation for criminal prosecution. All ratings received exceeded 4.0 and averaged 4.9 out of a possible 5.0 (5.0 means strongly agree and 1.0 means strongly disagree).

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

## Veterans Health Administration

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



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

## **Employee Integrity**

### Theft/Diversion of Pharmaceuticals

- A former VAMC pharmacy technician, who was also a local union official, over a 3-year period stole approximately \$150,000 in pharmaceuticals from the VAMC and shipped them to two individuals who co-owned a commercial pharmacy service. He was sentenced to 5 months' home confinement, 5 years' probation and ordered to make restitution to VA of \$147,140. A second party in the case, previously employed both as a VAMC pharmacist and as president of the commercial pharmacy, was sentenced to 27 months' incarceration, 3 years' supervised probation, and ordered to pay restitution of \$154,000 to VA. This individual also agreed to settle his federal income tax liability for \$280,668 and to forfeit his state pharmacist's licenses in three states. A third individual, who was vice-president of the commercial pharmacy, was sentenced to 24 months' incarceration, 3 years' supervised probation, ordered to pay \$123,974 in restitution and \$10,000 in fines. The third individual settled his federal tax liability by providing a check for \$343,000 to the Internal Revenue Service at his sentencing. He is prohibited from working in the pharmaceutical industry as part of his future probation.
- A joint VA OIG, Federal Bureau of Investigation (FBI), and Drug Enforcement Administration investigation disclosed that a

VAMC pharmacist manipulated the VA pharmacy computer to generate fraudulent prescriptions for narcotics in the names of patients. After execution of search warrants disclosed diverted drugs and documentation in support of the crime, the individual confessed to possession and diversion of narcotics from the VAMC and resigned from Government service. Judicial action is pending.

- A VAMC registered nurse was terminated from Government service based on evidence disclosed through a joint VA OIG and VA Police investigation into diversion of controlled substances from the VAMC. The nurse provided a sworn statement wherein he admitted to diverting controlled substances to maintain his drug addiction, and further admitted making false entries on VAMC logs to cover his theft. He also admitted being under the influence of drugs while on duty. A criminal complaint was filed charging the nurse with possession of a controlled substance, alteration of a medical record, and theft of property. Judicial action is pending.
- A VAMC pharmacist was arrested after a joint VA OIG and VA Police investigation revealed that he had diverted drugs from the pharmacy's narcotics vault, destruction bins, and outgoing mail. As a result of a search incident to his arrest, and subsequent consent searches, narcotic substances were found, as well as two concealed knives. Some of the prescription containers found during the searches indicated that they were drugs that should have been mailed to veteran patients. Other containers indicated that they were unused medications that had been returned to the pharmacy for destruction. He faces charges of burglary, possession of controlled substances, theft of property, and possession of a concealed deadly weapon.

### Use/Sale of Illegal Drugs

Two individuals, the first formerly employed in the dental service at a VAMC, and the second currently employed as a housekeeper at the VAMC, were arrested pursuant to the issuance of a warrant for knowingly and intentionally possessing cocaine. During the arrest, numerous crack vials and a crack pipe were found in the apartment in which the two resided. A joint VA OIG and FBI investigation revealed that the individuals sold drugs to other VAMC employees and to undercover operatives on the grounds of the VAMC. After the arrest, both were arraigned and released on \$10,000 personal recognizance bonds. Soon after being released, the former dental clerk was arrested again for violating the conditions of her pretrial release. She was arraigned before a Federal magistrate and incarcerated pending acceptance into a drug treatment program.

### Theft and Embezzlement

- A former VAMC driver was arrested on an outstanding warrant for theft of Government funds. A VA OIG investigation disclosed the individual had used a Government Fleet Service Credit Card to make more than \$4,000 worth of unauthorized gasoline purchases for use in personally owned vehicles. The individual fled and had been a fugitive for 5 months. He was arraigned in U.S. District Court and released on \$100,000 bond.
- A husband and wife, both of whom were employed as VAMC medical ward clerks, each pleaded guilty to one count of bank larceny and were subsequently sentenced for executing a scheme to obtain credit cards in the names of VAMC patients. The husband was sentenced to 6 months in a halfway house, 5 months' home detention, 5 years' probation, and restitution in the amount of \$25,905. The wife was sentenced to 6 months' home detention, 5 years' probation, and joint responsibility with her husband for

restitution in the amount of \$25,905. The husband stole pre-approved credit card applications from mail that was to be delivered to hospital inpatients on his ward. They applied for 12 cards under the names of VA patients and obtained cash and merchandise totaling approximately \$25,905. The victims were all patients hospitalized for treatment of Post Traumatic Stress Disorder resulting from psychological trauma experienced during their military service.

- A former VAMC practical nurse was indicted in U.S. District Court on 29 counts of bank fraud and 2 counts of forgery. Investigation disclosed that the nurse stole personal checkbooks from inpatients and wrote checks to himself, forging the veterans' signatures. He also forged the endorsement of two U.S. Treasury checks made payable to one of the veterans. Several checks were written after the veterans expired at the VAMC. The total loss is approximately \$33,350.

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

Five individuals were indicted by a Federal grand jury for mail fraud in connection with a scheme to submit false claims to a VAMC. One of the individuals, a maintenance supervisor, was terminated from the VAMC after he was indicted on nine counts of mail fraud. Other individuals named in the indictment worked for companies that supplied construction materials and/or services to the VAMC. A joint VA OIG and FBI investigation disclosed the maintenance supervisor assisted four separate vendors in using the mail to submit false claims for materials and services in exchange for providing him gifts and money.

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## Workers' Compensation Benefits Fraud

- A former VAMC motor vehicle operator was ordered to pay the Government \$175,000 in restitution after he admitted submitting false statements in order to receive Federal workers' compensation benefits. He acknowledged that, during the same period of time, he owned and operated a restaurant. In addition, he was sentenced to 6 months' home confinement and 5 years' probation.
- A former VAMC laborer was sentenced to 12 months' incarceration, 36 months' probation, and ordered to make \$5,886 in restitution, in response to a guilty plea to workers' compensation fraud. Investigation disclosed that he submitted false claims and false statements to the Government indicating he was unable to work due to an on-the-job injury when, in fact, he was working at a convenience store. As a result of the successful prosecution of this matter, the Government will realize future savings of \$201,042 in payments that he will not collect.
- A former VAMC pharmacy assistant was sentenced to 4 months' home confinement, 4 years' probation, and ordered to pay \$57,870 in restitution for making false statements and using a false social security number. A joint VA OIG, Department of Labor (DOL) OIG, and Social Security Administration (SSA) OIG investigation disclosed that, while receiving workers' compensation benefits for an injury received at the VAMC, she also worked at a private retail outlet. During this time, she continued to report to the DOL that she was unemployed. Loss to VA was in excess of \$52,000.
- A VA Outreach Center specialist pleaded guilty to a nine-count indictment charging him with workers' compensation fraud, mail fraud, and false statements. He allegedly injured his back in 1984 while lifting a bundle of papers at

work, and began receiving workers' compensation payments which have exceeded \$300,000. A joint VA OIG and DOL investigation revealed that, during the time he was receiving benefits, he was working among other things as: a counselor at a children's school, a psychologist at an elementary school, an adjunct professor at a university, the owner of a transportation company, co-director of a psychotherapeutic evaluation program and a preschool, and a self-employed psychologist. Sentencing is pending.

## Other Employee Misconduct

- A VAMC engineer resigned employment and paid restitution of \$3,800 after a VA OIG investigation revealed that he had misused his Government VISA IMPAC credit card by making personal purchases. A consent search of the individual's home by VA OIG agents disclosed items purchased for personal use using the card.
- A former VAMC nurse was sentenced to 15 months in prison and 3 years' supervised release, with the judge recommending referral to a mental health program during her incarceration. The nurse had been found guilty of making a telephone bomb threat to the VAMC in which she had worked in retaliation against co-workers who reported her as a suspect in numerous deaths at the facility. As a result of the bomb threats, patients were evacuated from the building which housed the intensive care unit.
- A VA physician, conducting research both as a VA employee and under the auspices of a private firm, failed to account properly for work hours performed by VA employees and to delineate between hours applied to VA projects versus his private research. Investigation revealed poor management practices, coupled with inadequate instruction and lack of oversight, which enabled the breakdown of accountability. The individual reimbursed the VAMC-affiliated

non-profit research entity \$44,705, which represented VA's total contribution to the research efforts.

- A joint investigation by VA OIG, IRS, and DOL disclosed that for almost 3 years, three VA employees participated in a scheme where they prepared false tax returns for other VA employees while working at the VAMC morgue, took kickbacks from funeral home directors, embezzled funds from the union office at the VAMC, issued checks to themselves and others for personal benefit, used the union's credit card to purchase personal items and services, and made false statements to DOL in annual reports the union submitted in order to conceal the embezzlement of funds. One of the employees, a former VAMC histopathology technician, pleaded guilty to conspiring to bribe a public official, mail fraud in connection with his attempted embezzlement of approximately \$190,000 from the union office, and falsely submitting personal tax returns. The second individual, a former VAMC morgue technician, who also served as union president, pleaded guilty to embezzlement of union funds, mail fraud, and making false statements to the DOL. The third party in the case, a former VAMC programmer assistant, who served as union secretary-treasurer, pleaded guilty to conspiracy to commit mail fraud, making false statements to the DOL, conspiracy to embezzle union funds, filing a false personal income tax return, and possessing a firearm in a Federal facility.
- An individual was sentenced to 42 months' imprisonment and 3 years' supervised release for having made misrepresentations to officials at a state university regarding the nature of a prior criminal conviction. He failed to reveal that he had been imprisoned in the 1980s for poisoning several co-workers, and this misrepresentation led to his acceptance by the university and subsequent VAMC residency position. During his current incarceration, he is prohibited from any work assignment in the

food, medical, or pharmaceutical sections of the prison. As a condition of his future supervised release, he is to undergo mental health counseling and allow unannounced searches of his residence. The individual has been the subject of numerous television and print media stories, regarding allegations that he had poisoned patients under his care both in the United States and in Africa.

- A former VA Medical and Regional Office Center employee was indicted on two counts of making false statements to the Government. A VA OIG investigation disclosed the individual claimed an ineligible person as a dependent on his application for compensation benefits. He consequently received over \$3,000 to which he was not entitled.
- A VAMC occupational therapy assistant, and his daughter, were both indicted on charges of mail fraud, wire fraud, and conspiracy. A joint VA OIG, Postal Inspection Service, and Secret Service investigation revealed that the two offered to sell merchandise on the Internet but, after receiving money from prospective buyers, failed to provide the merchandise. The daughter advised prospective buyers that the father was the contact person and gave his VAMC work number for questions about the merchandise. The father received phone calls from prospective buyers during his scheduled tour of duty, as well as having had payments in excess of \$14,000 sent to him at the VAMC.
- A former VAMC registered nurse was terminated from employment and pleaded guilty to making false representations concerning his education and experience in his VA employment application. A VA OIG investigation revealed that he submitted false documents claiming he had an Associate Degree, a Bachelor's Degree, assorted Certificates of Licensure, and a Master's Degree. Based on the falsified documents, he was hired initially as a staff nurse and was promoted to nursing care coordinator.

Loss to the Government due to increased salary payments exceeds \$500,000. Sentencing is pending.

- A former VAMC psychiatric unit registered nurse was indicted on one count of false statements. Investigation disclosed the nurse routinely slept during her shifts and made false statements to Federal agents when questioned on the subject. For the majority of the nights she worked, she was the only registered nurse assigned to the unit and the only staff member able to dispense medications to patients. Prosecution is pending.

### **Patient Abuse/Death**

- A former VAMC physician was found guilty of involuntary manslaughter and placed under house confinement following trial. A joint VA OIG and FBI investigation determined the physician injected an 86-year old patient with a lethal dose of potassium chloride against the advice of other caregivers present. Sentencing is pending, following a pre-sentence investigation.
- A practical nurse was terminated from a VAMC for abusing a patient, after a joint VA OIG and FBI investigation revealed that the nurse slapped the patient's face, resulting in facial cuts. During the course of the investigation, other patient abuse allegations involving other VA employees have surfaced. Criminal prosecution is pending.

### **Control of Drugs**

- A former VAMC patient was sentenced to 5 months' imprisonment and 12 months' supervised release on charges of selling diverted VA pharmaceuticals and making threats to a VA OIG source.

- An individual was indicted on charges of fraudulently attempting to obtain controlled substances. A VA OIG investigation determined that, while undergoing treatment as a patient, the individual removed blank VA prescription pads from two VA hospitals and forged prescriptions to obtain Percocet, a Schedule II narcotic and Darvocet, a Schedule IV narcotic.

### **Health Care Fraud**

- An individual was indicted on six counts of making false statements after a VA OIG investigation disclosed that he misrepresented himself as a veteran, using an identification card stolen from a veteran's wallet, in order to receive VA medical services to which he was not entitled. Loss to VA is estimated at \$100,000.
- Three former officers of a private nursing home pleaded guilty to conspiracy charges of filing false claims against VA and Medicaid, violating Federal tax laws, and committing wire and mail fraud. A joint VA OIG, FBI, and IRS investigation revealed the three created false billings for nursing home care of patients who had been discharged from the home, returned to VAMCs, or were deceased. The false claims resulted in a loss to the Government in excess of \$770,000. Sentencing and a related civil suit are pending.
- A telemarketing company employee who had been indicted on 15 counts of mail fraud pleaded guilty and was sentenced to 4 months' imprisonment, 4 months in a community correctional facility, 36 months' supervised probation, and restitution of \$5,245. The individual previously had pleaded guilty to one count of interstate commercial carrier fraud after a joint VA OIG and FBI investigation revealed that she was involved in a telemarketing scheme in which she impersonated a VA employee.

Investigation disclosed that the individual, who claimed to work for a VAMC, sold advertising space in the union newsletters to doctors and businesses by falsely representing that the VAMC had initiated a program where employees could choose their physician, pay for services at the time rendered, then receive reimbursement from the VAMC. She falsely represented to victim doctors, to obtain advertising, that they had ranked in the top five in an alleged poll of VAMC employees, when no such poll had been conducted.

- A former VAMC practical nurse, who operated a home health care service for veterans, was sentenced to 90 days' incarceration, 6 months' home confinement with electronic monitoring, 5 years' probation, and restitution. The nurse previously had pleaded guilty to charges of grand larceny, engaging in a scheme to defraud, and offering a false instrument for filing claims. In a joint VA OIG and Medicaid fraud unit investigation, the nurse admitted filing over 800 false documents with various entities including VA, billing for aspects of home health care she was reportedly providing to a quadriplegic veteran. She did not provide the services for which she billed and illegally subcontracted other services to non-licensed individuals who, in turn, cared for the veteran. The fraud is estimated to exceed \$350,000.

### **Theft of Government Property**

- An individual employed by a VA medical supplies contractor entered into a pretrial diversion agreement after being charged with theft of Government property. The agreement included 12 months' supervised probation and restitution of \$1,754. A VA OIG investigation revealed the individual, employed by the contractor to supply medical equipment to a state veterans home, sold equipment which should have been returned to the local VAMC and kept the money for personal use.

- An individual was arrested, arraigned, and released on his own recognizance after a joint VA OIG, Secret Service, and Postal Inspection Service investigation disclosed that the individual, a former Postal Service employee who worked part-time at a store, stole payroll checks intended for VAMC employees, and converted some of the checks for personal use. The checks were cashed at the supermarket where the individual was employed. A trial date is pending. In a separate incident, the individual was convicted on state charges for fraudulently negotiating stolen personal bank checks.

### **Armed Robbery**

An individual entered the Federal Credit Union at a VAMC before business hours and committed armed robbery. Posing as a deliveryman and asking for two credit union employees by name, he requested entry to deliver a package. Once inside, he brandished a handgun and tied up the employees. He emptied the safe, taking approximately \$147,000. VA OIG agents at the VAMC located a key witness to the crime, and set up an ad hoc task force with the local police, local county sheriff's office, and the FBI to establish and investigate leads. A suspect was arrested and approximately \$144,000 was recovered. Judicial action is pending.

### **Construction Related Fraud**

- The owner of a firm used to launder fraudulently obtained titles to real property was sentenced to 41 months' confinement, 36 months' supervised probation, fined \$75,000, and ordered to make restitution of \$293,189. An attorney in the case was sentenced to 37 months' incarceration, 36 months' probation upon release, and was ordered to make restitution of \$1,531,419, of which approximately \$100,000 is

payable to Government agencies. A third individual was sentenced to 24 months' probation and 75 hours of community service for tampering with a witness. All of the individuals were members of a real estate development and investment syndicate that used assets as collateral on personal surety bonds issued to VA, other government agencies, and contractors. Collateral consisted of real property on which the conspirators had obtained fraudulent titles and inflated assessments. The owner of the firm was instrumental in the acquisition of fraudulent title to, and false valuation of, property that was used as collateral for a personal surety bond on a VAMC construction contract.

- Two individuals have been charged in a 23-count indictment returned by a Federal grand jury with, among other things, conspiring to make false statements, bribery of an official, submitting false payroll reports, perjury, and supplying false information to a Federal grand jury. The two individuals are officials of a private construction company. A joint VA OIG, DOL, and Department of Defense investigation disclosed that, over a 2-year period, the individuals instructed a subcontractor to submit false payroll reports to a DOL investigator certifying that they paid a federally-mandated minimum hourly wage rate for renovation at a VAMC. The indictment further alleges these individuals and other construction company employees conspired to submit false payroll reports to the subcontractor. In addition, one of the individuals allegedly paid \$1,000 to the president of the subcontracting company to influence his statement to DOL about the wage payments. False payroll reports also were submitted to the Department of the Army for the subcontractor's work at an Army facility.

## Veterans Benefits Administration

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

## Loan Guaranty Program Fraud

### Loan Origination Fraud

- An individual employed as a property management broker for VA and her spouse pleaded guilty to charges of conspiracy to defraud VA. A VA OIG investigation disclosed that the couple aided an individual in purchasing several VA portfolio properties, providing false information to VA to qualify the individual for the loans. In addition, the couple submitted false loan origination documentation using a friend as a "straw" buyer in order to purchase a VA property for themselves in violation of law and VA regulations. All the properties purchased as a result of the conspiracy are currently in foreclosure. Sentencing is pending.

- An individual pleaded guilty to charges of fraud against the Government and was sentenced to 27 months in prison and 36 months' supervised probation. A joint investigation by VA OIG, FBI and SSA OIG revealed that, over a 3-year period, the individual, who worked as a realtor, and three co-conspirators were involved in a scheme to defraud VA by submitting false claims and statements concerning the purchase of 26 VA owned properties. The individual falsified employment and credit histories on mortgage qualification documents for individuals not otherwise financially qualified to purchase the properties. Sentencing of the co-conspirators is pending.
- The owner of a realty firm was sentenced in U.S. District Court to 12 months' confinement, and 5 years' supervised probation. He had earlier pleaded guilty to one count of wire fraud in connection with the activities of his firm and signed a forfeiture order directing him to relinquish assets totaling \$987,785. A joint VA OIG, HUD OIG, and FBI investigation disclosed the individual participated in the purchase of low-cost distressed properties, cycled them through front companies to inflate their assessed value, and then sold them to fraudulently qualified applicants.
- A VA beneficiary was sentenced to 12 months' incarceration, 24 months' supervised probation, and mandatory participation in a substance abuse recovery program for two violations of state health and safety codes for possession with intent to distribute dangerous drugs and cultivation of controlled substances. The individual had pleaded guilty to the charges, after approximately 10 pounds of marijuana were seized at her residence during the execution of a Federal search warrant by VA OIG agents. The controlled substances were discovered during a search for records and other evidence of fraud against VA. The case was the result of a joint VA OIG, Postal Inspection Service, and state employment department investigation into

allegations that the individual gave false statements to obtain a VA guaranteed loan.

### Equity Skimming

- A letter was issued by the Director of the VA Loan Guaranty Service debarring two individuals and their companies for a period of 3 years. A joint VA OIG and HUD OIG investigation completed earlier this year disclosed the two individuals assumed home loans on two VA guaranteed properties and eight HUD insured properties, collected rent money from tenants placed in the homes, but failed to make payments to the lenders. They then proceeded to file bankruptcies in fictitious names on the 10 properties, stalling foreclosure and enabling them to continue collecting rents. One of the individuals, a law student, was sentenced to 30 months' incarceration, 5 years' probation, ordered to pay a fine of \$5,000 and make restitution of \$24,220. The second individual was sentenced to 12 months' incarceration, 3 years' probation, ordered to pay a fine of \$2,500 and restitution of \$24,220.
- An individual was convicted in U.S. District Court on 1 count of equity skimming, 7 counts of mail fraud, 8 counts of bankruptcy fraud, and 11 counts of money laundering. A joint VA OIG and HUD OIG investigation disclosed the individual had fraudulently assumed over 50 properties whose mortgages were guaranteed by VA or insured by HUD, rented the homes, and retained the proceeds collected in rent rather than paying the lenders. His actions caused the loans to go into default and led to subsequent foreclosure action by the lenders. During the time the properties were being rented, the individual stalled foreclosure action by filing multiple bankruptcies under fictitious names, and laundered the illegal proceeds through bank accounts. The individual faces a maximum sentence of 20 years' imprisonment, a maximum fine of \$500,000, and court mandated restitution.



## **Beneficiary Fraud**

### **Employee Misconduct**

- After a lengthy jury trial, three individuals formerly employed as VA Regional Office (VARO) veterans benefits counselors were found guilty in U.S. District Court of conspiracy to defraud VA. A joint VA OIG and FBI investigation, with the assistance of the VA OIG Office of Audit, determined that six VARO employees had embezzled over \$1 million dollars from VA. An earlier indictment charged that the six individuals, while employed as benefits counselors and under the guise of providing assistance to veterans, submitted fraudulent claims for medical expenses. They then demanded a kickback of a portion of the payments from the veterans. Veterans' claims examiners processed and approved the claims based on the false information provided in the scheme. Three other employees previously pleaded guilty to the charges. Sentencing for all six conspirators is pending. This is the second major investigation involving fraudulent medical claims submitted to a VARO to generate payments to poor veterans in which substantial kickbacks were subsequently paid.
- A former VA Medical and Regional Office Center rating specialist was sentenced in U.S. District Court to 90 days house arrest, 36 months probation, a \$5,000 fine, and was required to make restitution of \$20,494 to VA. The sentence was in response to a previous plea of guilty to one count of mail fraud. A VA OIG investigation revealed the individual had devised a scheme for obtaining VA benefits to which he was not entitled by making false representations as to his unemployability. This scheme caused numerous VA checks to be delivered to him by the U.S. Postal Service.
- A former VARO ratings specialist was arrested by VA OIG special agents and later

indicted by a Federal grand jury on one count of theft of Government property. A joint VA OIG and FBI investigation disclosed that, while employed at VA, the individual created a fictitious veteran; prepared a bogus VA claims file; and awarded this fictitious veteran benefits for service connected disabilities. The individual then opened a savings account in the name and social security number of the fictitious veteran and had the benefit checks electronically deposited into that account. The indictment alleges that every month the individual withdrew almost the entire amount of the check in cash. He received over \$624,000 in VA benefits in the name of this fictitious veteran. He was arrested as he withdrew \$10,000 from the account. Numerous documents found in his possession identified him as the fictitious veteran.

### **Compensation & Pension Benefits Fraud**

- An individual was indicted in U.S. District Court for forgery of the endorsement on four U.S. Treasury checks. The charges were the result of a joint VA OIG and SSA OIG investigation which revealed that the individual continued to negotiate VA and SSA benefits checks made payable to her mother after the mother's death in 1987. The loss to the Government is approximately \$95,000.
- An individual pleaded guilty in U.S. District Court to one count of theft and was subsequently sentenced to 6 months' incarceration with work release privileges, 3 years' supervised release, and was ordered to pay \$35,702 in restitution. The guilty plea resulted from a VA OIG investigation which determined that, for more than 6 years, the individual submitted eligibility verification reports to VA which falsely stated she was not married when, in fact, she had re-married, in order to continue to collect widows' pension benefits to which she was no longer entitled.

- An individual employed as a national service officer with the Disabled American Veterans (DAV) was interviewed by VA OIG agents regarding his acceptance of funds from a veteran in exchange for assisting the veteran in submitting a claim for VA benefits. The individual confessed to taking \$500 from the veteran and, after the interview, admitted his actions to his supervisor. After receiving the information, the DAV terminated his employment. Additional reviews are being conducted to determine if other veterans were victims of this scheme.
- An individual was indicted by a Federal grand jury on two counts of making false statements to the Government. A joint VA OIG and SSA OIG investigation disclosed that, for approximately 4 years, the individual submitted false claims to VA for service connected disability, claiming that he was unemployable when, in fact, using a false name and social security number, he was employed as a construction worker. Loss to the Government is in excess of \$40,000.

### Dependency & Indemnity Compensation (DIC) Benefits Fraud

- An individual was sentenced in U.S. District Court to 5 months' imprisonment, 5 months' home confinement, 2 years' probation, and was directed to pay restitution to VA, after pleading guilty to four counts of wire fraud in connection with the theft of \$83,680 in VA compensation benefits. She admitted during a VA OIG investigation that she made no effort to notify VA of the death of her mother, a VA beneficiary, and continued to withdraw compensation benefits disbursements that were electronically deposited into the mother's bank account.
- An individual pleaded guilty in U.S. District Court to charges of conversion of Government

funds and was sentenced to 3 years' supervised probation and was ordered to pay \$68,122 in restitution to VA. A VA OIG investigation uncovered that the individual, the daughter of the widow of a deceased veteran, converted to her own use DIC funds electronically deposited into a joint account she held with her mother, who died in May 1986.

- The daughter of a VA DIC benefits recipient pleaded guilty in U.S. District Court to one count of theft of Government funds in response to the filing of a criminal information. A VA OIG investigation disclosed the daughter failed to notify VA of her mother's death in November 1989 and continued to spend electronically deposited funds totaling \$54,574. Sentencing is pending.
- An individual was sentenced in U.S. District Court to 6 months' home confinement with electronic monitoring, 5 years' probation, and ordered to pay \$103,116 restitution to VA. A VA OIG investigation disclosed that, over a 15-year period, the individual converted for his personal use more than \$100,000 in DIC benefits paid to his deceased mother.
- An individual employed as a VAMC housekeeping aide pleaded guilty in U.S. District Court to one count of theft of Government funds and was sentenced to 5 months' incarceration, 5 months' home confinement, and 36 months' supervised probation. A VA OIG investigation revealed that, for almost 15 years, he had improperly converted VA DIC benefits issued to his deceased mother. The total amount of funds converted was more than \$86,000.
- An individual was indicted in U.S. District Court on 21 counts of theft of Government property, 1 count of forgery, and 8 counts of bank fraud. A VA OIG investigation disclosed that, over a 6-year period, he fraudulently received and negotiated his deceased mother's VA DIC

benefits. The loss to the Government was approximately \$70,000.

- An individual was sentenced in U.S. District Court to 6 months' home confinement, 36 months' probation, and ordered to pay \$27,330 in restitution after pleading guilty to charges of theft of Government funds. A VA OIG investigation revealed the individual failed to notify VA of his mother's death and, over a 3-year period, continued to access DIC benefits funds totaling \$27,332 that were electronically deposited into her bank account.
- A former recipient of VA DIC benefits and Social Security survivor benefits pleaded guilty in U.S. District Court to a one-count criminal information charging her with theft of Government property. Subsequently, she was sentenced to 6 months' home confinement, 5 years' probation, and ordered to pay \$48,455 in restitution. A joint VA OIG and SSA OIG investigation disclosed the individual, the widow of a deceased veteran, remarried after the death of the veteran, but intentionally failed to report the change in marital status to VA or SSA, which would have terminated her benefits. For more than 4 years, she continued to collect benefits to which she was not entitled.
- An individual pleaded guilty in U.S. District Court to charges of theft of Government funds. The guilty plea was the result of a joint VA OIG and FBI investigation in which the individual admitted that, for more than 12 years, she converted to her own use VA DIC benefits checks issued in the name of her deceased mother. Loss to VA exceeds \$97,000. Sentencing is pending.

### Pension Benefits Fraud

- An individual was sentenced in U.S. District Court to 60 months' probation and ordered to make restitution to VA in the amount of

\$39,162, in response to a guilty plea to one count of theft of Government property. A VA OIG investigation revealed the individual, the widow of a deceased veteran, had improperly collected VA widow's pension benefits after failing to notify VA of her remarriage.

- An individual was arrested by VA OIG and FBI agents in connection with his fraudulent receipt of VA medical and pension benefits totaling \$54,000. The arrest was prompted by his failure to respond to a letter from the U.S. Attorney's Office requesting that he appear with counsel to address charges pending against him. The result of evidence developed in a VA OIG investigation revealed that he fraudulently received veteran's benefits, even though he had never served in the U.S. military.
- An individual pleaded guilty in U.S. District Court to charges that he made false statements to VA to retain eligibility for VA pension benefits, and was subsequently sentenced to 5 years' supervised probation and ordered to pay \$22,932 in restitution to VA. The plea was in response to evidence disclosed during a VA OIG investigation, which showed the individual, who was receiving VA benefits for himself and his spouse for a disability unrelated to his military service, had failed to report the receipt of significant unearned income by his spouse. Investigation revealed his spouse had received an inheritance in excess of \$450,000 and they had a net worth exceeding \$278,000 during a period in which VA contributed pension benefits to help defray their living expenses.

### Fiduciary Fraud

- An individual, who functioned as legal guardian for over 40 individuals and at least 2 disabled veterans, was arrested pursuant to a criminal complaint filed in U.S. District Court charging her with embezzlement, fiduciary fraud, and obstruction of justice. A VA OIG

investigation revealed that, for more than 15 years, VA had paid her to provide room and board for a veteran and had allotted up to \$2,000 per month, in her role as fiduciary for the veteran. For a 2-year period during that time, however, she did not care for the veteran herself, but rather left the veteran with her daughter, allegedly a drug addict who lived in a crime infested area, and paid the daughter \$700 a month to watch the veteran, keeping the remainder of the funds for her own use. She allegedly siphoned money from the second veteran's bank account by hiring her son to act as companion for the veteran, and then depositing checks made payable to the son into her own personal bank account. The obstruction of justice charge stems from her attempts to have individuals involved in the fraud lie to VA OIG special agents.

- An individual serving as fiduciary for his grandmother, a recipient of VA DIC benefits, was sentenced to 5 years' probation, directed to serve 250 hours community service, and pay fines and restitution totaling \$6,300. The sentencing was the result of a guilty plea to charges that he embezzled funds paid to him by VA for his grandmother's benefit.

### Educational Benefits Fraud

The civil division of a U.S. Attorney's Office is continuing to obtain civil settlements from student veterans who received VA benefits but did not attend regularly scheduled classes at a community college. Bribes were paid to faculty staff, including the chairman of a department at the college, to ensure that high grades would be given with no class attendance required. Most recently, the civil division has obtained settlement agreements from 46 additional students who have agreed to pay \$379,058 in restitution. The total number of students who have negotiated settlement agreements thus far with the civil division is 216, with total

restitution of \$2,633,638. Criminal action is pending against the college staff.

## **National Cemetery System**

A Federal grand jury returned an 11-count indictment against two individuals, the director of a VA national cemetery and a private contractor, who supplied sand and gravel to other contractors. Both have been charged with conspiracy to steal public property, conspiracy to commit mail fraud, theft of Government property, making false statements, and attempted witness tampering. The indictment alleges that the two conspired to remove and sell approximately 2,900 tons of sand from the cemetery.

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

Three former VA warehouse laborers were sentenced in U.S. District Court. The individuals had earlier resigned after pleading guilty to stealing Government property. The first individual was sentenced to 36 months' probation and ordered to make restitution of \$500 to VA for his role in the thefts. The second individual was sentenced to 6 months' home detention, 36 months' probation, and was ordered to pay \$5,657 in restitution to VA. The third individual was sentenced to 3 years' probation, 3 months' work release, and restitution of \$6,570. These individuals were among several, including current and former VA employees, identified in a joint VA OIG, FBI, and VA Office of Security and Law Enforcement long-term undercover investigation during which more than \$40,000 in stolen

Government property was sold to undercover agents, including items such as computers, printers, and office furniture. Additional sentencing actions are pending.

## OIG Forensic Document Laboratory

The OIG operates a Forensic Document Laboratory service for fraud detection. Requests routinely submitted to the laboratory include handwriting analysis, typewriting, inks, paper, photocopied documents, and suspected alterations of official documents. During this reporting period, the Forensic Document Laboratory received 1,214 documents from various non-OIG sources that required 3,161 laboratory examinations. The laboratory received 521 additional pieces of evidence in 5 OIG criminal investigations that required 1,362 laboratory examinations. There were a total of 34 forensic laboratory reports issued during this semiannual period.

There were 33 laboratory cases completed for the period as follows:

<b>Laboratory Cases for the Period</b>	
Requester	Cases Completed
OIG Office of Investigations	5
Regional Offices	23
VA Top Management	2
Security and Law Enforcement	1
U.S. Small Business Administration OIG	1
Federal Emergency Management Agency OIG and DOL OIG	1
<b>TOTAL</b>	<b>33</b>

The following are examples of laboratory work that was completed:

- The Chairman, Board of Veterans' Appeals (BVA) requested examinations of medical records contained in the claims folder of a veteran. A review of the medical records by BVA indicated the possibility of alterations. Laboratory examinations of handwriting, typewriter entries, and office copier generated documents were conducted on 39 medical records. The laboratory examinations determined that there had been 113 additions and alterations of the medical records. The veteran was identified as the author of 11 handwritten alterations and additions to the medical records.
- The Federal Emergency Management Agency (FEMA) requested laboratory examinations of documents that involved allegations that laborers of a federally funded public works contract were ordered to kickback up to 50 percent of their wages to the contractor. The federally funded project consisted of \$1.5 million in FEMA and Federal Highway Administration funds for damage repairs following the 1994 Northridge earthquake. There were 623 pieces of evidence examined in this joint FEMA OIG and DOL OIG investigation. The laboratory examinations identified the president of the corporation and two co-defendants as the authors of handwritten entries on 172 pieces of evidence.
- VA OIG investigated a veteran who received payments for home health care through the VA fee basis program. On some of the same dates the veteran was being paid by VA for home health care, he was hospitalized; the cost for this was paid by Medicare. Laboratory examinations were conducted to determine the validity of invoices submitted and to establish evidence of the double billing. The examination identified the veteran and his daughter as the authors of endorsements or handwritten entries

on 17 questioned U.S. Treasury checks and invoices for fee basis services. When confronted with the results, the daughter admitted that she had known it was double billing. The case is pending judicial action.



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# OFFICE OF AUDIT

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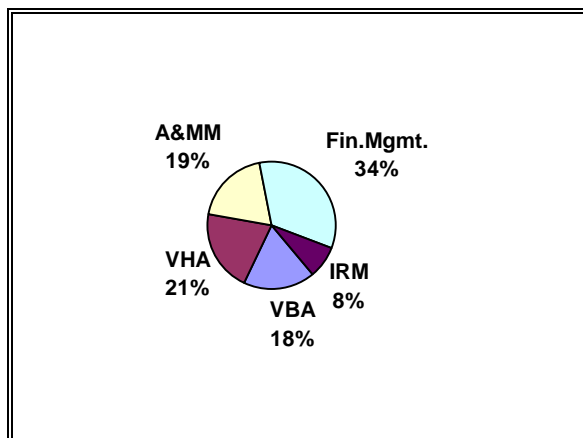
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## Mission Statement

*Improve the management of VA programs and activities by providing our customers with timely, balanced, credible, and independent financial and performance evaluations that address the economy, effectiveness, efficiency, financial, and internal control of VA operations, and that identify constructive solutions and opportunities for improvement.*

## Resources

The Office of Audit had 170 FTE assigned in VACO and 5 field offices throughout the country. The following chart shows the percentage of resources utilized in auditing each of VA's major program areas.



## Overall Performance

### Output

- Issued 20 program and financial audits and evaluations for an output efficiency of one report per 4.2 FTE.

### Outcome

- Made recommendations to enhance operations, correct deficient areas and effect \$370 million in monetary benefits.

### Cost Effectiveness

- Received a return of \$46 in monetary benefits for every dollar spent.

### Timeliness

- Completed 16 projects in an average of 392 calendar days.

### Customer Satisfaction

- Achieved a customer satisfaction survey rating of 4.2, on a scale of 5, for reports issued during the period.

Audits completed during the period identified opportunities to improve services to veterans, and identified savings that could be used to provide more and better service. For example, our evaluation of VHA's Medical Care Cost Recovery program concluded that VHA can enhance program recoveries by over \$83 million, providing additional funds to expand or improve medical services to patients. Our audit of the Pathology and Laboratory Medicine Service found that opportunities exist for VHA to increase savings by an estimated \$32 million annually by taking advantage of its purchasing power to obtain chemistry tests at a lower cost. An audit of VA's Workers Compensation program identified ways VHA could reduce program costs by about \$247 million, making these funds available for direct service-to-client purposes.

Following are summaries of some of the audits done during the reporting period by VA component. We discuss VHA, VBA, Office of Management, Office of Human Resources and Administration, Office of Information and Technology, and multiple office action.



# Veterans Health Administration

## Resource Utilization

**Issue: Management of Pathology and Laboratory Medicine Service (PLMS).**

**Conclusion: VHA is improving operations of PLMS.**

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

We conducted a series of audits of VHA's laboratory operations during FYs 1996-1998. The overall objective of these audits was to determine whether pathology and laboratory services were provided in an economical and efficient manner. The mission of PLMS is to provide medical diagnostic laboratory testing and transfusion functions at all VHA medical centers and outpatient clinics.

During FY 1997, PLMS employed approximately 7,200 employees nationwide, had a budget of over \$570 million, and reported performing over 105 million diagnostic and research related tests. Thus, PLMS represents a significant utilization of resources and has an important role in the provision of medical care to VHA's veteran population.

Overall, we concluded that PLMS was generally operated in a satisfactory manner. Audit results showed that laboratory tests were performed timely, and that all laboratories and blood banks were accredited. Quality control tests were routinely performed to ensure accurate test results, repetitive testing had been reduced, and laboratory supplies inventories were managed to prevent waste. Additionally, VHA undertook several new initiatives to improve PLMS operations, including implementing a new workload reporting system and developing new procurement strategies. However, we identified

some program areas in which VHA could improve operations.

We issued three reports which addressed the need to: (i) reduce procurement costs for chemistry tests by consolidating facility workloads (\$32 million annually), (ii) reallocate unused laboratory instruments procured for the Mobile Laboratory initiative (\$10.2 million), and (iii) capture unreported workload representing \$5 million in resources. The audit also found that PLMS needed to monitor quality control testing, staffing, and send-out tests more closely. We estimated that over \$2 million annually could be saved by increasing oversight over the cost of quality control testing.

We recommended the Under Secretary for Health take action to ensure that: (i) the cost of laboratory quality control testing is more aggressively monitored, (ii) PLMS staffing is assessed by Veterans Integrated Service Network (VISN) Directors to ensure that all positions are justified, and (iii) the costs of tests sent out by the laboratory are analyzed to ensure that it is more cost-effective to send out the tests than perform them in-house. The Under Secretary for Health concurred and provided an acceptable action plan in response to our findings, recommendations, and monetary benefits. We consider all issues in the report resolved. (*Summary Report: Audits of Pathology and Laboratory Medicine Service, 8R3-A01-149, 9/30/98*)

***“The information that you have shared with us has been very useful as we prioritize opportunities for improvement, and we appreciate the cooperative efforts of your auditors.”***

***Under Secretary for Health***

**Issue: Cost-per-test leases and reagent rental contracts.**

**Conclusion: VA can reduce laboratory costs by maximizing volume discounts and obtaining lower prices for chemistry tests.**

**Impact: Better use of \$32 million.**

The audit was conducted to evaluate the cost-effectiveness of using vendor-owned chemistry analyzers to perform laboratory tests. VISNs were using blanket purchase agreements (BPAs) to save about \$8 million annually in acquiring chemistry analyzers and associated supplies, but some VAMCs did not participate in BPAs, and consequently did not lower costs for non-routine tests compared to prior years.

Among those VAMCs that used BPAs, most did not achieve maximum allowable discounts. In addition, VHA did not monitor contract costs, or survey the Department of Defense (DoD) or non-federal hospital contract costs. As a result, VHA was paying more than some private hospitals with lower volumes paid for the same tests.

Opportunities exist for VHA to increase savings by an estimated \$32 million annually by taking full advantage of its purchasing power to obtain chemistry tests at a lower cost. Similarly, DoD could potentially save over \$25 million by improving its procurement practices. We recommended the Under Secretary for Health: (i) advise VISNs of the benefit of multi-facility agreements that include nearby DoD facilities to maximize volume-based discounts, (ii) instruct VISNs to perform cost-studies to determine the optimal configuration of equipment necessary to obtain laboratory tests at the lowest cost, (iii) ensure contracting officials make vendor proposals for cost-per-test agreements more uniform to allow meaningful price comparisons, and (iv) survey prices charged hospitals to identify the lowest vendor prices. The Under Secretary for Health concurred and provided an

acceptable action plan. (*Audit of Cost-Per-Test Leases and Reagent Rental Contracts in PLMS, 8R3-A01-101, 5/13/98*)

***“Your observations have been very helpful in identifying improvement opportunities.”***

***“We appreciate the cooperative efforts of your auditors in fully discussing with us all issues identified by VHA regarding report conclusions.”***

***Under Secretary for Health***

**Issue: Medical Care Cost Recovery (MCCR) program.**

**Conclusion: VHA can significantly increase MCCR recoveries.**

**Impact: Increase MCCR recoveries by \$83 million.**

The audit was conducted at the request of the Chairman, House Committee on Veterans Affairs, to determine whether VISNs have successfully implemented cost recovery programs and to identify opportunities to enhance recoveries. In FY 1997, the Under Secretary for Health established a minimum VHA collection goal of \$544.1 million.

We concluded VHA could enhance MCCR recoveries by requiring VISN Directors to manage MCCR program activities more actively. We recommended the Under Secretary for Health require the Chief Network Officer to improve program activities by establishing performance standards for staff involved in all phases of MCCR activities, monitoring performance results, taking action to improve performance gaps, and incorporating other billing and collection improvements. The Under Secretary for Health concurred with our findings

and provided an acceptable implementation plan. (*Audit of the Medical Care Cost Recovery Program, 8R1-G01-118, 7/10/98*)

## Facility Management

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

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

**Impact: Better use of \$1.6 million.**

We audited four nonrecurring maintenance projects as part of an ongoing national audit of Minor Construction and Nonrecurring Maintenance.

### Energy Management Project - VAMC Ann Arbor

We conducted the audit to determine whether an energy construction project was necessary or whether alternatives existed that would provide the required services in a more cost-effective manner. Results showed that elements of the overall energy management project were unnecessary or not cost effective.

Overall project plans included 20 energy-saving measures identified in a Department of Energy study. One element involved installing occupancy sensors throughout the medical center and another involved installing a variable air volume system to improve the efficiency of the heating, ventilating, and air conditioning system in research rooms. We found the cost to install occupancy sensors would not be recouped in energy savings and encouraging staff to turn the lights off was a less costly alternative that could achieve much of the energy savings anticipated by the project. Also, the cost to install the variable air system in research rooms with fume hoods would not be recouped in energy savings.

We recommended these portions of the project be cancelled. The VAMC Director agreed with our recommendations and provided acceptable implementation plans. (*Audit of Energy Construction Project at VAMC Ann Arbor, Michigan, 8R5-D02-133, 8/12/98*)

***“We appreciate the efforts by the review team and their subsequent recommendations.”***

***Director, VAMC Ann Arbor***

### Road and Parking Lot Construction, VA Domiciliary White City

We conducted the audit to determine if a construction project to build a road and pave a gravel parking area was necessary or whether cost-effective alternatives existed that would provide the required service. The project called for building a new road adjacent to an existing gravel parking lot adjacent to a baseball field, to create a second entrance to the domiciliary. The new road would be paved and would include curbs and gutters, sidewalks, and lighting. The project also included plans to repair existing roadways and parking lots, including the parking lot serving the baseball field.

We concluded that the portion of the project to pave the baseball field parking lot was not necessary, and the estimated cost of \$243,300 could be better used for other purposes. The existing gravel parking lot was in good condition and met the needs of the facility. We recommended the Domiciliary Director eliminate the portion of the project to pave the baseball field parking lot. The Domiciliary Director agreed with our recommendation and provided acceptable implementation plans. (*Audit of Nonrecurring Maintenance Construction Project at VA Domiciliary White City, Oregon, 8R5-D02-127, 7/24/98*)

Adult Day Care Center, VAMC Asheville

We conducted the audit to determine whether a construction project to add an Adult Day Health Care (ADHC) was necessary or whether alternatives existed that would provide services in a more cost-effective manner. We concluded the project was not necessary and continuing to contract for ADHC services would be more cost-effective.

Plans called for a private firm, already under contract to the medical center, to provide off campus ADHC services and to also operate a campus based ADHC program in renovated medical center space. To accommodate the ADHC program, management planned to renovate space and relocate other services within the building proposed for the ADHC program. The ADHC contractor would offer the medical center a reduced rate for providing ADHC services in the renovated space.

We concluded that project was not cost effective because there were only 13 veterans currently using this program. In addition, the contractor was planning to open ADHC centers in several other locations within the city in the next few years, making ample resources available should additional veterans become eligible for the program.

We recommended canceling the project and that VISN officials ensure current needs have been assessed when medical centers submit projects for approval. The Director, VISN 6 agreed with our recommendations and provided acceptable implementation plans. (*Audit of Adult Day Care/Clinics Construction Project at VAMC Asheville, North Carolina, 8R5-D02-107, 5/28/98*)

Pharmacy Renovation, VAMC San Francisco

The project called for renovation of the outpatient pharmacy and installation of an

Optifill-II automated prescription-filling system. We concluded the cost to renovate the pharmacy, estimated at \$936,050, could be better used for other purposes.

Audit results showed the pharmacy workload did not justify the need for automated prescription filling equipment. Implementation of 90-day refills and the Consolidated Mail Outpatient Pharmacy program had reduced the pharmacy workload. Current staff was completing prescriptions in a timely manner, and dispensing was not significant.

We recommended the VAMC Director cancel the project and return the Optifill-II equipment to the manufacturer or make the equipment available for use by another VAMC which can demonstrate a need for the equipment. We also recommended the Director, VISN 21 ensure that needs are thoroughly addressed when projects are submitted for approval.

The Director, VISN 21 agreed that needs assessments are necessary and stated they have mechanisms in place to screen high cost purchases for appropriateness. However, he stated they would consider whether changes to the process are needed based on our comments.

The VISN Director did not agree to cancel the project, but he proposed an alternative to reduce the scope and cost of construction by \$115,950. He provided additional justification for purchases of the equipment and stated alternative action (cancellation of the equipment purchase contract) is not feasible at this late date due to an associated monetary penalty.

We reviewed the additional justification provided, and while some of the Director's points are valid, we remain unconvinced there is adequate workload to justify purchasing the automated equipment. However, since the contract cannot now be economically cancelled, we accepted the reduction in scope as the best

option available. We consider all issues resolved. (*Audit of Pharmacy Renovation Project at VAMC San Francisco, California, 8R5-D02-139, 9/10/98*)

## Veterans Benefits Administration

### Delivery of Benefits and Services

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

**Conclusion: Increased management oversight can improve data integrity for selected VBA Government Performance and Results Act (GPRA) performance measures.**

**Impact: Enhanced customer service.**

At the request of the Assistant Secretary for Policy and Planning, we initiated a multi-stage audit to examine the integrity of the data used for GPRA reports. This is the first in a series of audits to evaluate the validity, reliability, and integrity of data relating to some of VA's most critical GPRA performance measures.

This audit assessed the accuracy of data supporting three VBA GPRA performance measures: (i) average days to complete original disability compensation claims, (ii) average days to complete original disability pension claims, and (iii) average days to complete reopened compensation claims.

The overall project examined data processing systems to determine whether data were processed accurately and whether there were adequate controls to prevent bad data from processing. We also compared source documents to data input into the automated system to determine if the data had been accurately transferred. This report addresses the

first component. A second report will be issued at a later date to address the second component.

Our analysis of FY 1997 data for the three VBA performance measures found that internal controls did not prevent invalid data from processing. VARO personnel were able to input or change data to show better timeliness than actually achieved, and inclusion of pre-discharge processing times distorted the average processing times reported under GPRA. Pre-discharge processing refers to a new program to begin processing claims before a veteran is discharged from active military duty.

Data used to calculate the three performance measures lacked integrity because input commands could be used to show better timeliness than actually achieved, and VBA did not retain transaction data. The temporary nature of transaction data also makes VBA vulnerable to reporting errors and system manipulation. We also concluded that pre-discharge processing time should not be incorporated into the average processing times used for GPRA reports.

Since transaction data are routinely deleted, they are not available for management review and oversight. We concluded that availability of transaction data in conjunction with an onsite inspection program can identify system manipulations or errors and help to ensure the accuracy of GPRA data.

We recommended that VBA: (i) collect and analyze historical transaction data to identify questionable or suspect transactions, (ii) institute onsite field inspections at VAROs, and (iii) establish policy for reporting processing time on pre-discharge processing activities. The Under Secretary for Benefits concurred with the recommendations and provided acceptable implementation plans. (*Audit of Data Integrity for VBA Claims Processing Performance*)

*Measures Used for Reports Required by the GPRA, 8R5-B01-147, 9/22/98)*

## Other Beneficiary Issues

**Issue: Reasonableness and accuracy of administrative expenses.**

**Conclusion: Administrative expenses reported for FY 1997 were reasonable and accurate in all material respects.**

**Impact: Assuring program integrity.**

At the request of the VA Insurance Service, we evaluated FY 1997 Life Insurance Program administrative expenses. The purpose of the evaluation was to assess the reasonableness and accuracy of administrative expenses incurred and reported for VA's Life Insurance Programs, and verify the allocation methodology used to assign costs among insurance programs.

We determined that FY 1997 administrative expenses totaling \$37.5 million were reasonable and accurate in all material respects. Also, the allocation methodology used to assign costs among insurance programs was proper. We did not make recommendations. (*Evaluation of the Life Insurance Programs' Administrative Expenses, 8R1-B12-130, 7/31/98*)

***"An excellent example of cooperation with program staff. The final report provides important independent verification that our expenses and allocations are appropriate and accurate."***

***Customer Survey Response***

## Office of Management

### VA's Financial Statements

**Issue: VA's Consolidated Financial Statements (CFS) for FYs 1997 and 1996.**

**Conclusion: Some assets may not be adequately protected and resources may not be properly controlled.**

**Impact: Improved stewardship of VA assets and resources.**

Our audit of VA's CFS for FY 1997 and 1996 included a qualified opinion concerning balances for receivables, liabilities for loan guarantees, and resources payable to U. S. Treasury contained in VA's Statement of Financial Position, and related items in the Statements of Operations and Changes in Net Position, Cash Flows, and Budgetary Resources and Actual Expenses. In each of these areas, we were unable to satisfy ourselves as to the recorded balances in these accounts because of inadequate accounting records. Nor were we able to satisfy ourselves as to the balances by other auditing procedures.

Our report on internal control structure discusses five material weaknesses concerning VA-wide information system security controls, Housing Credit Assistance (HCA) program financial reporting, HCA program direct portfolio loans, HCA program loan sales accounting, and medical facility receivable balances. We made recommendations addressing these weaknesses and believe the issues in these five areas should be considered for inclusion as material weaknesses in the Department's Federal Managers Financial Integrity Act reporting.

Our report on compliance with laws and regulations discusses three noncompliance issues. One dealt with noncompliance with Federal Financial Management Improvement

Act requirements concerning HCA program financial management information systems and VA-wide information system security. We also identified noncompliance with two other laws concerning requirements for charging interest and administrative costs on compensation and pension accounts receivable, and requirements for funding minimum staffing levels in the VA OIG that, while not material to the financial statements, warranted disclosure.

Except for the noncompliance with Federal Financial Management Improvement Act requirements, the report concludes that for the items tested, VA complied with those laws and regulations materially effecting the financial statements.

The Acting Assistant Secretary for Management provided comments indicating the Department was addressing the issues we reported. (*Report of Audit of VA Consolidated Financial Statements for FYs 1997 and 1996, 8AF-G10-103, 5/18/98*)

**Issue: Financial Management.**

**Conclusion: Five management letters were issued to assist the Department in improving financial management.**

**Impact: Improved financial reporting and control.**

As part of the CFS audit, we issued five management letters addressing financial reporting and control issues. The management letters provided Department managers additional observations and advice that, while not material in relation to the CFS, will enable the Department to improve day-to-day accounting operations and controls. The management letters contained observations concerning: (i) VBA Finance Center operations; (ii) life insurance program accounting activities; (iii) accuracy of property, plant, and equipment reporting and controls; (iv) expenditure transactions; and (v) payroll transactions.

No conditions were noted that had a material effect on the FY 1997 CFS, but correction of the conditions is considered necessary for effective operations. Where needed, appropriate adjustments were made to financial statements. (*i. Management Letter, Fiscal Year 1997 Consolidated Financial Statements – Veterans Benefits Administration Finance Center Hines, IL, 8R4-G10-128, 7/29/98; ii. Management Letter, Fiscal Year 1997 Financial Statements, VA Life Insurance Programs and Selected Loan Guaranty Program Financial Activities, 8R1-G10-106, 5/29/98; iii. Accuracy of Property, Plant, and Equipment Financial Information, 8AF-G10-102, 5/27/98; iv. Management Letter – Expenditure Transactions, 8AF-G10-141, 9/10/98; and v. Management Letter – Payroll Transactions, 8AF-G10-140, 9/10/98*)

## Office of Human Resources and Administration

**Issue: Government Travel Card Program.**

**Conclusion: The program was efficiently operated, and VA initiatives will improve minor problems identified.**

**Impact: Better serve the needs of VA.**

The purpose of this audit was to determine whether the Program was effectively implemented, operating efficiently, and meeting program objectives. The program was developed to improve the purchase of transportation services, subsistence, and other travel expenses, better serve the needs of VA travelers, and improve cash management and administrative procedures. As of September 1997, VA had over 21,600 active individual cardholders and over 300 government travel accounts. Individual and government

transactions during FY 1995 through 1997 totaled over \$126 million.

We found the program better served the needs of VA and improved cash management by: reducing travel advances, reducing administrative workload associated with issuing and administering cash advances and government transportation requests, and providing management more information on how travel funds were being spent.

Audit results showed the need to: provide more timely processing of travel vouchers and payment of government travel account invoices, make better use of reports provided by the credit card contractor to monitor the program at both VACO and individual facilities, and increase use of travel cards to obtain advances. VA program officials have initiated or plan to take action in each of these areas, and therefore, we made no recommendations. (*Audit of the Government Travel Card Program, 8R3-G01-123, 7/14/98*)

***“The Office of Administration is pleased with the results of this report.”***

***Deputy Assistant Secretary for Administration***

## Office of Information and Technology

### Security Controls

**Issue: Security controls for the Integrated Data Communications Utility (IDCU).**

**Conclusion: Security controls need to be strengthened to ensure that IDCU operations are adequately protected.**

**Impact: Improved ADP security.**

The audit evaluated the adequacy and appropriateness of security controls for the IDCU. The IDCU is a Department-wide data communications network enabling VA users to connect from one automated system to another and to access various VA databases. Over 500 facilities are currently connected to the IDCU, enabling customers at each of these facilities to communicate with each other, and to access and transmit key information and data in support of VA's mission of providing patient care and delivery of benefits to the nation's veterans.

Maintaining appropriate network security measures is important given the significance of the financial transactions and data that is transmitted over the IDCU annually associated with VA's \$40.4 billion budget. Accordingly, the IDCU needs to be protected from security breaches, interruption of service, unauthorized access, inappropriate disclosures, or destruction of data.

The audit identified key security enhancements that would help make the IDCU more secure and ensure continuity of operations. Some of these enhancements were identified in prior OIG security audits at VA Data Processing Centers. Improvements were needed in: (i) physical security, (ii) controlling access to the IDCU from remote sites, (iii) establishing employee



access clearances for contractors and VA staff, and (iv) security controls to protect sensitive information while in transit from site to site. VA should continue to monitor the security of VA Internet gateways as a Management Control Internal High Priority Area. In addition, VA needs to ensure user billings provide sufficient information to allow customers to accurately assess their actual IDCU usage and reconcile annual customer billings.

The Acting Assistant Secretary for Management concurred with the findings and recommendations and provided appropriate implementation actions. (*Audit of Security Controls for the IDCU, 8D2-G07-066, 4/23/98*)

***“These findings and recommendations will assist us during our decision making process.”***

***Deputy Assistant Secretary for Information Resources Management***

## Multiple Office Action

### Other Financial Control Issues

**Issue: Workers’ Compensation Program (WCP) cost.**

**Conclusion: Improved management can lessen VA’s risk for abuse, fraud, and unnecessary payments.**

**Impact: Reduction of program costs by \$247 million.**

The audit was conducted to identify opportunities to reduce costs associated with WCP claims. During FY 1998, VA payments for WCP costs to the Department of Labor (administrator of the Federal Employees’ Compensation Act) will total about \$140.8

million. We estimated that in Charge Back Year (CBY) 1996 there were 567 fraudulent WCP cases totaling about \$9 million.

We concluded that WCP costs could be reduced by conducting more effective case management to identify employees who can be brought back to work or who should be removed from the rolls. Improved case management could have avoided \$17.5 million in WCP costs during CBY 1996 and could avoid future costs of \$246.9 million over the projected 18 year lifetime of claimants on the rolls.

The audit also identified the following additional areas where program management could be enhanced by: (i) collecting and using “Continuation of Pay” cost information as a management tool for monitoring WCP cost and employee health and safety issues, (ii) establishing more comprehensive WCP policies and procedures that take advantage of best practices and proven case management methods identified in our review, and (iii) providing all VHA facilities with access to the Workers Compensation Management Information System and completing certain modifications to enhance use of the system.

The Assistant Secretary for Human Resources and Administration and the Acting Assistant Secretary for Management concurred with the report recommendations and provided appropriate implementation actions. (*Audit of VA’s Workers’ Compensation Program Cost, 8D2-G01-067, 7/1/98*)

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**Issue: VHA's management of non-medical care cost recovery receivables.**

**Conclusion: VHA is acting on \$225 million of receivables.**

**Impact: Improved collection of receivables.**

We reviewed VHA management of receivables other than those related to recovery of medical care costs. Results showed that a significant portion of the \$225 million balance in non-medical care receivables may not be collected. VHA's Chief Financial Officer has set out a plan to have VAMCs review these accounts and determine which remain collectable. Those accounts found to be collectable would be subject to appropriate collection actions, and a proper accounting would be made of the remainder.

The VHA plan is appropriate and our tests showed that implementation is progressing as designed. Recommendations were made to support their effort, which will result in collections of almost \$4 million at the 8 sites we visited, and collect up to \$70 million additional at the 165 remaining sites. The Under Secretary for Health and Acting Assistant Secretary for Management agreed with our recommendations. (*Audit of VHA Actions on Accounts Receivable, 8AN-G01-117, 8/6/98*)



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# OFFICE OF HEALTHCARE INSPECTIONS

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## Mission Statement

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

## Resources

The Office of Healthcare Inspections (OHI) has 20 FTE assigned, all of whom work in OIG headquarters. These individuals are deployed 100 percent in healthcare inspections and evaluation issues.

## Overall Performance

### Output

- We published 15 final reports during the reporting period.

### Outcome

- We made 33 recommendations, resulting in improving both clinical care delivery and management efficiency.

### Customer Satisfaction

- Program managers' satisfaction and acceptance level of our work was an average of 4.4 on a 5.0 scale for the year.

OHI inspectors have continued to emphasize the need for VHA to strengthen its quality management infrastructure by developing and pursuing a variety of quality management (QM) related projects and reports. These projects included reviews of VHA's Deployment of QM Staffing and Resources; an Analysis of the Ten Most Frequent Substantiated Hotline Allegations over a 3-year Period; an Analysis of VHA

Acutely Ill Inpatient Demographic Descriptors; and an Oversight Analysis of VHA's Implementation of Selected Aspects of its Patient Safety Improvement Policy. OHI also strengthened its VHA quality of care oversight by developing a more deliberative process for selecting and assigning Hotline allegations, which will ultimately improve our ability to complete and report on these reviews more promptly. We also established closer working relationships with Veterans Integrated Service Network (VISN) clinical managers in our ongoing effort to strengthen the quality program assistance (QPA) review process. This strengthened relationship helped us to use the QPA effectively in the context of inspecting several sensitive Hotline allegations at VAMCs.

## Veterans Health Administration

### Nationwide Healthcare Program Reviews

**Report: Demographic Descriptors of VHA's Acute Care Patient Population, 8HI-A28-105, 5/22/98**

Issue: Unique demographic, socioeconomic, and environmental characteristics of the average VA inpatient.

Conclusion: Hospitalized patients have problems that complicate their treatment.

Impact: Enhanced ability to plan patient accessibility and treatment strategies.

A 1995 OHI report showed that a significant percentage of VHA patients, who were occupying acute care beds in 24 randomly selected VAMCs on June 8, 1994, did not need

acute care. Nevertheless, OHI believed that these patients were extremely chronically ill, and had other impairments that justified their need for some level of care. This factor became more important as VHA began to reduce beds and bed days of care, and aggressively began to evolve from a hospital-based, specialized care model to one of ambulatory-based care with a primary care emphasis.

This report summarizes and consolidates OHI's findings and conclusions. It aimed at providing VHA planners and clinicians with information to develop strategic plans to enhance patient access to care and to rationally plan for the extended care services that an increasing number of VHA patients need. The report is an analysis of selected demographic, socioeconomic, and environmental descriptors of 499 patients whose care we reviewed in FY 1995. The review analyzed variables that describe important characteristics such as patients' mortality, admission frequency, length-of-stay, accessibility to VA care, availability and adequacy of social support systems, and patients' nutrition risk.

We found that about 32 percent of the 499 patients were so chronically infirm that they succumbed to their illnesses within 18 months of their June 1994 episodes of inpatient care. We also found the average patient traveled more than 46 miles to obtain VA care, that 44 percent of the patients had inadequate social support systems to help them sustain an adequate lifestyle when they were not hospitalized, and more than 80 percent were not adequately nourished to sustain good health. We also found that VHA clinicians do not consistently record vital information about patients' social support systems or their nutritional status – information that is important in successfully maintaining these patients in an ambulatory care status.

The Under Secretary for Health agreed with our report findings and consultative

recommendation and provided positive comments as to VHA's contemplated actions to address these issues.

**A Description and Analysis of OHI's Most Common Findings in Hotline Inspections: Fiscal Years 1993-1995, 8HI-A28-150, 9/28/98**

Issue: VHA employee behaviors and health care practices engender complaints to OIG's Hotline.

Conclusion: Stakeholders complain mostly about how employees treated them, either clinically or personally.

Impact: Managers can focus remedial efforts to areas and behaviors frequently associated with stakeholder tensions.

The OIG Hotline opens about 800 cases each year; these cases raise substantive health care, managerial, and fiscal concerns. OHI assigns high priority to accepting and inspecting congressional requests, cases that have major medical implications, and serious cases that VHA managers have not been able to resolve to the complainant's satisfaction. In the 3-year period from October 1992 through September 1995, OHI closed 230 hotline cases, 72 of which resulted in formal reports with recommended corrective actions.

This report analyzes the 122 substantiated or partially substantiated allegations that we inspected and discussed in the 72 formal reports. OHI inspectors substantiate or partially substantiate about 25 percent of all of the allegations that they review. This represents only an extremely small portion of the millions of employee/patient interactions that occur in VHA healthcare facilities every year. Nevertheless, it is important that VHA and Department managers are aware of what issues create difficulties or concerns for the people whom we serve – veterans and their families.

More than 58 percent of all substantiated allegations stem from patients and their family members.

From our perspective, most complainants express concerns about the manner in which VHA employees treated them, both from a clinical and interpersonal standpoint. We found, for example, that 28 percent of the substantiated allegations dealt with clinicians' provision of inappropriate or incorrect treatment; 8 percent pertained to delayed diagnoses or treatment; 5 percent involved lapses in patient and family safety procedures, such as flawed infection control procedures; 12 percent involved verbal or physical abuse or sexual harassment of a patient or family member; and 5 percent identified impersonal or uncaring application of administrative procedures. The tenor of these substantiated allegations emphasizes the need for VHA managers to continue to improve patient satisfaction and to resolve problems as they occur at the local level.

The Under Secretary for Health agreed with our findings and consultative recommendations and provided plans to disperse the findings to VAMC and VISN managers in order to apprise them of the improvement areas that they need to emphasize to strengthen the manner in which patients and other stakeholders are treated.

**Suggested Supplementary Statistical Options for Monitoring Healthcare, 8HI-A28-151, 9/29/98**

Issue: Need for prompt detection of adverse QM changes to ensure patient safety and care.

Conclusion: OHI offers an alternative statistical methodology proven to detect changes in quality.

Impact: The ability to detect adverse QM changes facilitates early detection and correction.

On October 25, 1995, the Deputy Under Secretary for Health testified before the House Veterans Affairs Committee that VHA would develop a strong statistical analysis capability in each VISN. The purpose of this statistical capability was to facilitate early detection of adverse changes in selected clinical monitors that may signal the onset of unwanted clinical behaviors or practices that could adversely affect patient care.

OHI offered to assist VHA to establish a strong statistical capability. In that spirit, this particular report offers VHA a tested statistical methodology that OHI has successfully used to identify subtle changes in health care quality monitors long before other commonly used methods can. This statistical method is based on an analysis of time-series data, which OHI has found, by experience, to identify changes in monitors very effectively. This is particularly true for those monitors that track mortality very early, and which far exceed the capability of other commonly used health care monitors which were unsuccessful in detecting any variations in the monitoring data at all.

We believe, that if properly applied to existing VHA automated data bases, this statistical method will enhance VHA's ability to have an early warning system of unwanted changes in selected quality management continuous monitors. We did not make any recommendations in this particular report, but commend the statistical methodology to VHA managers for their use.

## QPA Reviews

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

Conclusion: Managers are working collaboratively to reorganize the health care process to provide good, responsive services, but the scope of changes often negatively affects employee morale.

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

### **Report: QPA Review Program Oversight Review Report and Analysis, 8HI-A28-124, 7/14/98**

For more than 3 years, OHI has been developing a workable, credible methodology to review essential aspects of VAMC clinical operations and patient treatment processes in an effort to provide consultative recommendations to VHA managers on ways to strengthen the manner in which they provide care to their veteran clientele. This process is built on the administration of structured questionnaires to executive and mid-level managers, and large random samples of clinicians, patients, and operating level employees. The questionnaires elicit information that measures perceptions about the quality, responsiveness, and acceptability of health services that the particular medical center and its employees provide to patients.

OHI actively solicited the assistance of leaders in all of the VAMCs in which we conducted QPAs, to provide us with critical comments and suggestions that would help to make the QPA process a meaningful and valuable tool for managers to use in improving their patient care services. We also solicited support and suggestions from the VHA's VISN clinical managers in order to ensure that VHA understood the process and that senior VHA

clinicians helped us to properly focus the reviews to obtain and analyze the most useful information. The clinical managers who participated in the QPA development and refinement process, and participated in two such reviews, fully supported the process

### **Reports: QPA Reviews, VAMCs Lyons, NJ, and Washington, DC, 8HI-F03-125, 7/16/98, and 8HI-F03-145, 9/17/98**

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

In both QPA reviews, OHI inspectors concluded that medical center executive managers were working collaboratively to initiate programmatic changes that were designed to improve veterans' access to high quality health care and were developing and implementing strategies that reduced operating costs, and allowed them to reprogram funds so that more money would be available for direct patient care.

In both cases, executive and mid-level managers held positive attitudes about the changes that were underway. Similarly clinicians were generally very supportive of the organizational and operational changes that had occurred and believed that these changes had improved the quality and accessibility of patient care. Patients also had generally positive impressions about the improvements in care, accessibility, and employee attitudes that occurred in association with the changes.

Notwithstanding these positive impressions, as we reported in our previous semiannual report, employees who responded anonymously to our

QPA questionnaires raised concerns that the pace and scope of the many organizational and operational changes that have occurred have increased personal tensions and reduced employee morale. Employees appear to attribute their concerns to uncertainties about job security, and perceived increased workloads or insufficient staffing situations in their particular work areas. Executive managers at both VAMCs have established intensive communication initiatives to keep employees and other stakeholders fully informed about ongoing and contemplated organizational and operational changes, but employees continue to hold negative impressions about the change process.

OHI continues to be concerned that the issues of degraded employee morale, and increased tensions in the workplace, have the potential to lead to diminished quality of care, lowered patient satisfaction, or adverse patient incidents. Thus, we believe that VHA managers need to seriously consider ways to alleviate these employee problems.

## Healthcare Hotline Inspections

### Inspection of Alleged Medication System Problems, Colmery-O'Neil VAMC Topeka, KS, 8HI-A28-111, 6/2/98

Issue: Automated medication dispensing system.

Conclusion: The system did not reduce the time required to medicate patients, but decreased the occurrence of medication errors.

Impact: Patient safety increases as a result of decreased incidence of medication errors.

We inspected allegations that VAMC managers had forced nursing employees to implement an

ill-conceived, poorly designed medication delivery system that depended on the local centralized computer system to authorize nurses to medicate patients. The complainant charged that this system resulted in increased numbers of serious medication errors, was extremely frustrating to work with, required more time than the previous system to deliver medications, and was initiated without nursing input or consent.

Our inspection found that the VAMC's automated medication delivery system had been in place for about 1 year and that it was operating effectively. We did not substantiate the allegations that the system resulted in increased numbers of serious medication errors. To the contrary, the system prevents nurses from administering unauthorized medications unless the nurse overrides the system and administers the drug in spite of electronic warnings. Incident reports that we reviewed showed that reportable medication errors occurred only when nurses ignored the system. Thus, the automated system had been instrumental in virtually eliminating serious medication errors.

The automated system actually does extend the time that nurses previously needed to administer medications, because of the time that nurses need to check internal control points more carefully before they administer a drug. The increased time is not appreciable, and nurses told us that they easily accommodate the additional time requirement.

We found that nurses participated in developing the automated system from its inception, and that local Information Management Section (IMS) employees worked closely with all nursing employees until they were proficient in operating the system. IMS employees provide virtually round-the-clock support and consultation if nurses encounter problems with the system. This intense IMS support has served to reduce nursing frustrations that arose from



implementing a new and unfamiliar system. We did not make any recommendations.

**Inspection of Alleged Mistreatment of a PTSD Patient, VAMC Iowa City, IA, 8HI-A28-116, 7/1/98**

Issue: Insensitivity to post-traumatic stress disorder (PTSD) symptoms and patient's needs.

Conclusion: Clinicians properly treated a patient, but did not fully appreciate the gravity of his psychiatric symptoms which led to him seeking an early discharge.

Impact: Better care for emotionally distressed PTSD patients.

We inspected allegations that VAMC clinicians failed to provide adequate care for a PTSD patient. We concluded that VAMC clinicians properly managed the patient's medical condition by ordering appropriate diagnostic evaluations and admitting the patient for observation and treatment at a time when he was at risk of developing barium aspiration pneumonia.

Clinicians did not threaten the patient with loss of his disability benefits if he refused to accept care, as the complainant alleged. However, clinicians did not apparently fully appreciate the patient's exacerbated psychiatric symptoms that disrupted his normal sleep patterns, and a nurse did not provide him with an ordered sleeping medication. The patient viewed this refusal of sleep medication as an insensitivity to his needs and asked to be discharged against medical advice.

We recommended that the Director order nursing managers to provide in-service training on enhanced communication about individual patients' needs. The Director acknowledged a lack of knowledge in this area, particularly as it applies to PTSD patients' needs, and initiated

actions that properly responded to our recommendation.

**Inspection of Alleged Inappropriate Medical Care and Transfer of a Nursing Home Patient, VAMC Huntington, WV, 8HI-A28-121, 7/13/98**

Issue: Inadequate surgical cardiology care and unjustified cardiac surgery.

Conclusion: Patient treated properly, but transferring him to a private nursing home was probably not in his or his family's best interests.

Impact: Improved coordination of care for complex medical conditions.

We inspected allegations that clinicians neglected and provided inappropriate care to a patient, and that the patient's care was so deficient that it directly resulted in his death. A critical aspect of this case was the urgency of performing coronary bypass graft surgery, during which, or immediately after which, the patient suffered a stroke from which he never recovered.

A senior VHA cardiothoracic surgeon from a different VISN reviewed the patient's clinicians' decisions and assessments regarding surgical urgency and appropriateness. He concluded that the surgical intervention was both timely and appropriate given the patient's precarious condition. VAMC surgeons clearly and succinctly explained to the patient, the risks, benefits, and complications associated with the surgery. The patient's post-operative care was well managed by clinicians when he was transferred back to his home VAMC.

However, OHI concluded that clinicians' decision to transfer the patient from the VAMC to a private sector nursing home was probably not in the patient's or his family's best interests. The patient's deteriorating medical condition led to his return to the VAMC within a short time.

The coordination of the patient's medical care was complicated by the involvement of many physicians and three VAMCs. This complexity resulted in some lapses in effective communications with the family.

We made two recommendations aimed at improving the coordination of complex patient care cases after hospitalization and for obtaining patient's and family members' input and consent for nursing home placement. The Director agreed with our recommendations and provided reasonable implementation plans.

**Inspection of Selected Clinical Issues in a Patient's Care, VAMC Atlanta, GA, 8HI-A28-122, 7/13/98**

Issue: A patient experienced numerous unsatisfactory treatment experiences during six episodes of hospital care.

Conclusion: Medical errors and omissions occurred, but the errors did not contribute to the patient's death.

Impact: Correcting several issues will improve the overall care of patients.

We inspected a series of allegations pertaining to clinical and administrative misadventures that a patient had during the course of six episodes of inpatient care from 1976 through 1995. A physician had not heeded a drug allergy alert and wrongly prescribed a medication to which the patient was allergic, but clinicians recognized the error before the patient had a reaction. Clinicians did not properly follow up on out of line laboratory tests and did not promptly treat a kidney condition. The patient had to spend excessive time in the Emergency Room (ER) before he was admitted for an acute illness. Clinicians failed to recognize emerging pressure ulcers immediately and did not promptly provide relief for the patient's increasing pain. Clinicians recognized that the patient's nutrition status was deteriorating, but they did not immediately evaluate the condition

objectively and prescribe corrective treatment. The patient and his family members were often unable to talk to the patient's physicians because of frequent teaching rotations.

Also the patient and his family made clinicians aware of the patient's wishes on the level of care he was to receive at the end of his life, but responsible clinicians did not properly record this information or communicate it to the treatment staff. No clinical employees other than the social worker apparently ever counseled the patient or his family about the death process.

We substantiated or partially substantiated all of these allegations. We made 12 recommendations aimed at correcting the deficiencies that led to these events. The Director agreed with all recommendations but one, and provided responsive implementation plans to reduce the possibility that similar incidents would reoccur. The Director did not concur with our recommendation to revise resident and attending rotation procedures in order to provide better continuity of patient care, citing the affiliated medical school's resistance to such a change. However, he agreed to enter into discussions with the medical school to improve this issue.

**Inspection of Patient Care Allegations and Quality Program Assistance Review, VAMC Lyons, NJ, 8HI-F03-125, 7/16/98**

Issue: Unsatisfactory use of sterilizing equipment, unclean nursing home conditions, and inadequate staffing.

Conclusion: Unwanted events occurred, but managers promptly corrected the conditions.

Impact: Improvement in care and safety.

Several complainants raised concerns that clinical employees were not properly sterilizing endoscopy equipment, and that this negligence put patients at risk of incurring dangerous

infections; that there was a scabies epidemic among Nursing Home Care Unit (NHCU) patients that managers were aware of but did not correct; and that the VAMC was in a dangerously understaffed condition as a result of its consolidation with another VAMC and subsequent down-sizing.

We confirmed that an endoscopy technician had developed a homemade endoscope sterilizing attachment when the factory made equipment malfunctioned, and employees used the unauthorized attachment. However, infection control and laboratory employees conducted numerous tests on the equipment to ensure that it had been properly sterilized and did not find any indication of surviving pathogens on the equipment after sterilization using the unauthorized equipment. They subsequently procured a properly authorized, functional attachment.

The NHCU had three scabies outbreaks in a 3-year period of time. This phenomenon occurs with relative frequency among elderly, infirm patients. However, clinicians recognized the condition each time and implemented proper treatment and prophylaxis to prevent its further spread to other patients.

The VAMC did experience a staffing reduction in selected patient care areas as a result of rapid staffing cutbacks and recruitment lag time. These conditions were exacerbated by employees' high level of emergency annual and sick leave usage. The Director immediately authorized recruitment of 30 additional nursing employees which nursing managers distributed according to need.

We conducted this inspection in conjunction with a QPA which showed that managers were working collaboratively in order to implement many major organization and operational changes. But even though managers were meeting regularly with employees, and

maintaining high profiles in all areas of the medical center, they did not fully appreciate the depth and severity of employee morale problems.

We made several recommendations aimed at preventing similar problems that we identified during our inspection visit from reoccurring. The Director agreed with our recommendations and implemented satisfactory corrective actions.

### **Inspection of Alleged Inappropriate Medical Care, VAMC Tuskegee, AL, 8HI-A28-129, 7/28/98**

Issue: Alleged improper treatment of acute pneumonia.

Conclusion: Clinicians provided adequate and timely care to treat a patient's acute respiratory failure.

Impact: High quality patient care.

We inspected allegations that VAMC clinicians improperly inserted an endotracheal tube into a patient's airway, unnecessarily placed her on mechanical ventilation, caused her pain when they suctioned her airway, refused to prescribe opiates to relieve her discomfort, refused to obtain expert consultation to treat her pulmonary problems, and refused to allow her sister to administer chest physiotherapy in the intensive care unit.

We could not substantiate any of these allegations. The patient had long-term chronic pulmonary disease and was a heavy smoker. She developed pneumonia that rapidly progressed into acute respiratory failure. Her clinician properly intubated her and initiated mechanical ventilation. He is a cardiologist who is knowledgeable in treating pulmonary problems so he did not need outside consultation, and the patient's rapid recovery of pulmonary function demonstrated his skills. The physician properly did not prescribe opiates for the patient's discomfort since narcotics are

respiratory depressants and this would only have exacerbated her pulmonary problems. There is no question that suctioning an airway is a very uncomfortable procedure; however, it appears that clinicians used proper and accepted procedures in carrying out this procedure, thereby facilitating the patient's ability to breathe.

Since we did not identify any problems with this patient's care, we did not make any recommendations.

**Inspection of Alleged Inattentive and Inadequate Care for a Veteran's Chest Pain, VAMCs Birmingham and Montgomery, AL, 8HI-A28-132, 8/13/98**

Issue: Inattentive treatment for a patient's complaints of chest pain.

Conclusion: Nurses and a physician did not provide timely treatment.

Impact: A patient's death may have been preventable.

We inspected the circumstances surrounding a patient's allegedly preventable death in a VAMC's Ambulatory Care Unit. The family alleged the patient had complained at length that he was having severe chest and arm pain, and that in spite of these complaints, clinicians made him wait an excessive amount of time in the patient waiting area, without being seen by a clinician. When the patient became more distressed and began asking loudly to be seen, a resident physician confronted him and told him if he was in such distress, he should go to the ER to be seen. A nurse transported the patient to the ER where he died shortly after arriving.

The Office of Medical Inspector had reviewed this case but had not interviewed family members. We concurred with the Office of Medical Inspector that clinicians failed to recognize the patient's distress and reacted improperly to his anxieties and entreaties for

help. We made several recommendations aimed at reducing the possibility that similar events would occur in the future.

The Director agreed with our findings. He immediately contacted the patient's family, communicated our findings and conclusions to them, and provided them with proper counseling. He also provided implementation plans that will properly carry out our recommendations.

**Inspection of Alleged Mistreatment of a Respite Care Patient, VAMC Atlanta, GA, 8HI-A28-136, 8/26/98**

Issue: Home treatment for a hospital incurred condition.

Conclusion: Clinicians provided proper treatment for a traumatic injury of the urethra.

Impact: Establishment of standard catheter anchoring procedures.

We inspected the circumstances surrounding the alleged improper treatment of a patient whose catheter anchoring tape had inadvertently migrated into his urethra. The complainant alleged that clinicians failed to properly treat the resultant condition and attempted to cover up their error.

Our inspection found that clinicians had anchored the patient's urinary catheter to his leg with non-allergic tape, and that the tape apparently became dislodged from the catheter and migrated along the tube and into his urethra. This caused the patient to bleed around the catheter and created intense discomfort. VAMC Home Care nurses and a physician immediately examined the patient at home and remedied the problem. The patient's discomfort continued and his spouse transported him to the ER late in the evening, where a resident physician examined but did not treat the patient and sent him home.

We concluded the VAMC did not have a standard method for anchoring urinary catheters and recommended that they standardize procedures in this regard. We also recommended that clinicians be reminded about the necessity to clearly communicate with patients and their family members as to what they found on examination, and what treatment is needed, if any. The Director agreed with our recommendations and implemented appropriate corrective actions.

**Inspection of Allegations Pertaining to the Psychiatric Service, VAMC North Chicago, IL, 8HI-A28-137, 9/1/98**

Issue: Medical treatment for psychiatric patients.

Conclusion: Managers took appropriate action.

Impact: Medical procedures established.

We inspected the circumstances surrounding several allegations that managers did not appreciate the need to treat psychiatric patients' medical problems and that as a result of this problem, several patients had suffered unwanted consequences. The complainant also made several allegations regarding managers' lack of interest and follow up on an incident in which she alleges that one patient assaulted another patient who subsequently died of his injuries; and about patients who suffered ill affects of incarceration because VAMC clinicians failed to look after their interests at the time authorities took them into custody.

Our inspectors found that clinical and executive managers had taken appropriate actions to ensure that medical physicians routinely provided needed treatment to psychiatry patients who need medical assistance. Managers had not ignored the incident in which the patient allegedly died after another patient assaulted him. The patient died nearly 1 year after the incident, and he had a long history of severe

head trauma. Several expert neurological and pathology consultants told us that it was unlikely that the assault was associated with the patient's death.

We also found clinicians had provided appropriate follow up and treatment for patients who had been taken into custody, but the VAMC did not have an established procedure to ensure that patients had their prescribed medications when they were arrested and taken to jail. We recommended the Director establish such a procedure. He agreed with this recommendation and established an appropriate policy.

**Inspection of Alleged Mismanagement of Psychiatric Programs, William Jennings Bryan Dorn Veterans Hospital, Columbia, SC, 8HI-A28-152, 9/30/98**

Issue: Degraded psychiatric treatment associated with outpatient vs. inpatient treatment.

Conclusion: More patients have access to care.

Impact: Enhanced access, reduced cost, but effective treatment.

We inspected allegations that the quality of care in well established psychiatric programs had deteriorated since managers had revised them from predominantly inpatient to outpatient programs. We evaluated the treatment protocols for the Substance Abuse and Geropsychiatry Treatment programs and found they appear to be reasonable and consistent with outpatient treatment programs around the Nation.

We interviewed senior program clinicians, patients, and family members, all of whom were satisfied with the quality of care that these outpatient programs afford. Clinicians interviewed stated they had been consulted about the transition to outpatient care and agreed the outpatient method was probably superior, since there are drugs and procedures for these

patients that were not available several years ago. Also, patients appear to be more satisfied with their treatment since they do not have to be confined to a facility to treat their conditions.

The complainant also provided the names of 48 patients whose psychiatric clinician allegedly mistreated or did not treat adequately. We reviewed all but two of these patients' medical records and found clear evidence that clinicians treated them properly and followed up on their care needs after they were discharged. The two patients whose care we did not review had been transferred to other VAMCs and their records were not available to us.

Since we did not identify any problem areas, and did not substantiate the allegations, we did not make any recommendations.



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# OFFICE OF DEPARTMENTAL REVIEWS AND MANAGEMENT SUPPORT

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## Mission Statement

*Promote OIG organizational effectiveness and efficiency by providing reliable and timely management and administrative support, and providing products and services that promote the overall mission and goals of the OIG. Strive to ensure that all allegations communicated to the OIG are effectively monitored and resolved in a timely, efficient, and impartial manner, and independently conduct special inquiries into allegations concerning senior ranking officials and other high profile matters. Conduct contract reviews to assist contracting officers in price negotiations; to ensure that contractors submit accurate, current, and complete pricing data.*

The Office of Departmental Reviews and Management Support is a diverse organization responsible for a wide range of operational and administrative support functions. The Office consists of the following four Divisions:

I. Contract Review and Evaluation Division - The Division is responsible for conducting preaward reviews of Federal Supply Schedule (FSS) proposals, postaward reviews of FSS contracts, drug pricing reviews under the provisions of Public Law 102-585, and other work, such as providing technical assistance to contracting officers, VA General Counsel, or the Department of Justice for the preparation of trial or settlement cases.

II. Hotline and Special Inquiries Division - The Division is responsible for determining action to be taken on allegations received by the OIG Hotline. The Hotline section receives over 20,000 contacts annually, mostly from veterans, VA employees, and congressional sources. This

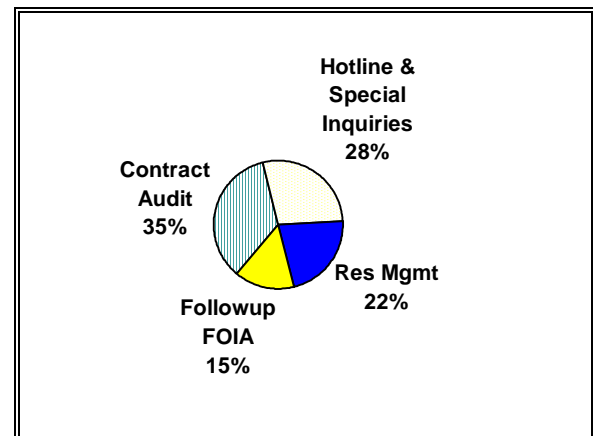
includes controlling and referring many cases to impartial VA components having jurisdiction. The Special Inquiries section reviews Hotline cases that involve allegations of misconduct and mismanagement by senior officials.

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

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

## Resources

The Office of Departmental Reviews and Management Support has 68 FTE allocated to the following areas.





## I. CONTRACT REVIEW AND EVALUATION DIVISION

### Mission Statement

*Assist VA in its efforts to become a world-class purchasing organization for health care items by providing contracting officers with reliable and timely contract review and evaluation services. Conduct preaward reviews to assist contracting officers in price negotiations by holding contractors accountable for the best prices; conduct postaward reviews to ensure that contractors submitted accurate, current, and complete pricing data in support of negotiations and, where warranted, recover overcharges; and conduct reviews to ensure that contractors adhere to the drug pricing provisions of Public Law 102-585.*

### Resources

The Contract Review and Evaluation Division has 23 FTE. These FTE are provided on a reimbursable basis from the Office of Acquisition and Materiel Management (A&MM) to perform contract reviews for VA.

### Overall Performance

#### Output

- The Division issued a total of 16 reports during the period, of which 9 were preaward contract reviews and 7 were postaward audits.

#### Outcome

- We returned \$31 for every \$1 expended on postaward activity and \$25 for every \$1 expended on preaward reviews. Dollar recoveries resulting from postaward audits

totaled \$14.3 million. Preaward reviews, designed to assist VA contracting officers in negotiating the best possible prices made recommendations that may save VA \$14.1 million.

### Customer Satisfaction Measures

- Customer satisfaction survey forms were used by VA contracting officers to provide feedback on the degree of satisfaction with our reviews. For this period, the average customer satisfaction rating was 4.9 out of a high of 5.

## Office of Management

### Postaward Audit Activity

**Issue: Prime vendor overcharges for pharmaceutical products.**

**Conclusion: Postaward review discloses overcharges.**

**Impact: Contractor agrees to refund \$9.4 million.**

Our review found that a pharmaceutical prime vendor had overcharged FSS customers \$9.4 million from January 1, 1998 through June 30, 1998. When the company converted to a new electronic ordering system in January 1998, VA customers immediately noticed an unusual number of pricing irregularities and reported their concerns to the National Acquisition Center (NAC). At the request of NAC officials, we reviewed FSS sales data and company disclosures and issued an interim report that confirmed continuing pricing irregularities and contract overcharges. The contractor has agreed to reimburse VA \$9.4 million. We are continuing to review the contracts to determine if additional money is owed VA.

**Issue: Contractor overcharges for wheelchairs.**

**Conclusion: Postaward review discloses overcharges.**

**Impact: VA recovers \$2.6 million.**

In a previous semiannual report, we reported that a contractor, supplying wheelchairs to VA and other Government entities under an FSS contract, overcharged government customers based on a postaward review. This period the contractor agreed to pay the Government \$2.6 million to settle the Government's claim under the False Claims Act.

The review concluded the contractor failed to provide accurate, complete, and current information regarding its sales and marketing practices, which resulted in the Government paying higher prices than similarly situated commercial customers. This review was especially complex because it involved the analysis and comparison of wheelchairs with literally hundreds of different configurations. The Department of Justice and OIG negotiated the settlement.

**Issue: Contractor overcharges for pharmaceuticals.**

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

**Impact: VA recovers \$2.3 million from three contractors.**

- A pharmaceutical company remitted \$2,150,000 to VA for contract overcharges resulting from not disclosing accurate, complete, and current pricing and discount information to the contracting officer during negotiations. The contractor's failure to disclose their most favored customer discounts denied the Government the opportunity to negotiate more favorable discounts.

- A pharmaceutical manufacturer voluntarily disclosed overcharges of \$140,000 resulting

from errors in the computation of Federal Ceiling Prices. We reviewed the self-audit and determined that the amount due was computed correctly. We also reviewed various commercial contracts to determine if there was any defective pricing or price reduction impact.

## **Preaward Review Activity**

**Issue: FSS vendors did not always offer best prices to VA.**

**Conclusion: Reviews recommend potential better use of funds.**

**Impact: VA may save \$14.1 million.**

Preaward reviews of FSS offers from contractors supplying dental supplies and equipment, X-ray film and equipment, and drug and pharmaceutical products show that contractors did not always initially offer best prices to VA.

- Three preaward reviews of X-ray film and equipment offers resulted in recommendations of potential savings of \$11.5 million.
- Five preaward reviews of dental supply and equipment offers resulted in potential savings of \$1.8 million.
- One preaward review of a pharmaceutical company's offer resulted in potential savings of \$800,000.

Potential savings result from recommendations to contracting officers to negotiate lower prices based on our review of the contractor's commercial sales practices.

**Issue: Measured effect of previously reported better use of funds.**

**Conclusion: Significant savings are sustained by contracting officers.**

**Impact: VA will save \$21.6 million over a 5-year contract period.**

In previous semiannual reports, we have identified significant potential savings to the VA relating to recommendations made on preaward reviews of FSS offers. To determine the effect of our recommended potential savings, we compared our original recommendations to the results of negotiations.

We now have received completed negotiation results related to six FY 1998 pharmaceutical preaward reviews containing recommended potential savings. The six preaward reviews contained recommended potential savings of \$23.7 million; VA contracting officers in negotiations were able to achieve savings to the VA of \$21.6 million over the projected 5-year contract period.

We will continue to measure the effect of the other preaward reviews completed in FY 1998 with recommendations amounting to \$174.8 million in potential savings. Upon receipt of the negotiation results, we will be able to determine how much of our recommended potential savings was achieved in negotiations.

### Other Contract Review

**Issue: Contractor claims overstated.**

**Conclusion: Contract review disclosed overstated claims against a VA contract.**

**Impact: Potential better use of \$334,000.**

A contractor submitted a settlement proposal and claims of \$578,000 to VA for costs incurred as a result of termination of a construction project. The contractor's termination settlement proposal and claims for equitable adjustment related to an alleged, Government-caused performance delay. We questioned \$334,000 of the claimed costs. The questioned costs pertained to all areas of claimed costs, but primarily related to an audit-determined contract loss adjustment computation. The review found the contractor would have incurred a monetary

loss if the contract had been completed and therefore the contractor was not entitled to the claimed profit.

## II. HOTLINE AND SPECIAL INQUIRIES DIVISION

### Mission Statement

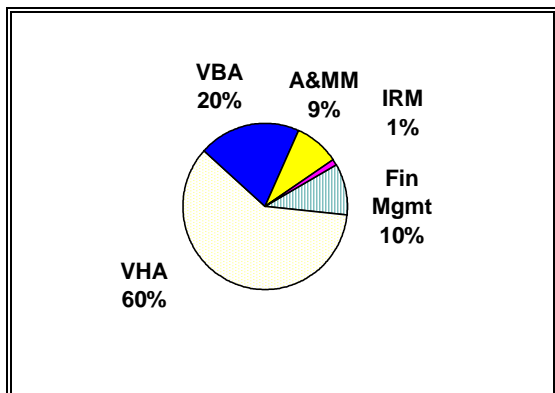
*Strive to ensure that mission related allegations communicated to the Division are responded to in an efficient and effective manner using OIG personnel or impartial VA officials, and independently review allegations concerning senior officials and other high profile matters.*

*The Hotline Section operates a toll-free telephone service 5 days a week, Monday through Friday, from 5 AM to 10 PM Eastern Time. Phone calls, letters, and E-mail are received from employees, veterans, the general public, the Congress, GAO, and other Federal agencies reporting issues of fraud, waste, and abuse. Due consideration is given to all complaints and allegations received, with each addressed by OIG or other Departmental staff.*

*The Special Inquiries Section reviews allegations against high-ranking officials and examines other high profile requests. Special inquiries staff independently conduct the administrative reviews and make recommendations for corrective actions to the Department.*

## Resources

The Hotline and Special Inquiries Division has 19 FTE assigned. In addition to the Division Director, there are 7 employees in the Hotline Section and 11 employees in the Special Inquiries Section. The following chart shows the percentage of resources utilized in reviewing allegations by program area.



## Overall Performance

During the reporting period the Hotline received 7,609 contacts. Of this number, 439 cases were opened. The OIG reviewed 64 of these and the remaining 375 cases were referred to VA program offices for review.

### Output

During the reporting period, Hotline staff closed 497 cases of which 103 contained substantiated allegations (21 percent). Of the closures, we responded to 80 Congressional inquiries received from Members of the Senate and House of Representatives. Special inquiries section staff closed 21 cases. Staff issued 9 reports and completed 12 administrative closures.

## Outcome

VA managers took administrative actions against 32 employees and 106 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled \$540,629.

## Customer Satisfaction

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

## A. HOTLINE SECTION

The Hotline Section retained oversight on a number of cases that were referred to other VA OIG elements as well as to independent VHA and VBA program officials for resolution. Hotline staff followup on issues such as patient care, veterans' benefits, employee conduct, property and personal gain. The following are some examples of the cases that were closed during this reporting period.

## Veterans Health Administration

### Patient Abuse

- A VHA review initiated by a Hotline inquiry confirmed allegations of misconduct, including patient abuse by a VA Domiciliary Director. The Director was removed from his position, given a 60-day suspension, demoted and reassigned to a staff nurse position.

- A Hotline inquiry to VHA found that a health care provider slapped a patient because he removed his oxygen mask. The health care provider received a 14-day suspension.

### **Patient Care**

- A VHA review initiated by a Hotline inquiry at a facility substantiated the need to improve health care procedures. The review found that poor record keeping resulted in a false diagnosis of cancer. Further, the review noted that family members were notified of the diagnosis before the patient. Senior officials apologized to the patient and offered further care at the same facility or on a fee basis with a private physician. VHA took action to implement improvements to several reporting systems as the result of the review.
- A Hotline inquiry sent to VHA found that a Family Nurse Practitioner was prescribing medications even though she had not fulfilled all of the VHA and State requirements for prescriptive authority. Corrective action was taken to remove the prescriptive authority from her previously approved Scope of Practice Statement and to review the credentials of all mid-level practitioners currently working with expanded authority to ensure that all met the minimum VHA requirements.
- A VHA review initiated by a Hotline inquiry substantiated that medical center staff unreasonably delayed paying a veteran's fee basis care provider for two years for the treatments he received. The VAMC admitted the error and paid the bills on four authorized treatments. The Director sent the veteran and his fee basis physician letters of apology.

### **Public Safety**

- A VHA review initiated by a Hotline inquiry confirmed there was an unsafe elevator at one facility. The elevator would unexpectedly drop

several floors and injured at least one employee. The review also found inadequate documentation to prove regular maintenance was performed. VAMC officials plan to work with the private elevator repair contractor on a regular basis until satisfactory performance is achieved and maintained.

### **Lobbying Restrictions and Using Government Time and Property**

- A Hotline inquiry to VHA substantiated that a VAMC probationary employee was using a VA computer to contact and request other VA employees to write their Congressional representatives to lobby against the President's FY 1998 budget. The employee also provided the others with a sample message arguing against the budget. The probationary employee was terminated from VA employment.

### **Contracting Activities**

- A VHA review initiated by a Hotline inquiry found that a VAMC contracting officer improperly removed an 8a firm from an awarded contract and gave the contract to a non-8a firm. The contracting officer also failed to act as mentor for the 8a firm. A GAO protest settlement set aside the second year of the contract so the contract could be rebid. The contracting officer's warrant was revoked.
- A VHA review initiated by a Hotline inquiry substantiated that an administrative officer improperly used an IMPAC card to purchase telephone answering machines at a VAMC. The administrative officer received a verbal counseling. All credit card holders and approving officials have been notified that this type of activity is prohibited and may lead to disciplinary action. The VAMC informed us that periodic reminders would be sent to reinforce this policy.

### **Using and Handling VA Stationary and Postage**

- A Hotline inquiry to VHA substantiated that an employee used VA stationary and postage for personal use. The employee was given a written counseling, informing him of the inappropriate action and instructions to refrain from any further use of government resources for personal matters. A Bill of Collection was issued to the employee to recoup the expense incurred by the government.
- A VHA review initiated by a Hotline inquiry found that a VAMC mailroom employee was inappropriately discarding “junk mail.” VAMC officials counseled the employee and directed that future decisions to discard mail be made by management.

### **Use of Government Vehicles for Official Business**

- A Hotline inquiry to a VISN confirmed that a manager at one of their facilities authorized the use of a VA bus for other than VA business reasons. The official permitted an Employee Association to transport VA employees for non-official purposes. The official was counseled, and the Chief Network Officer prepared a letter to all VHA facilities to prevent future occurrences.
- A Hotline inquiry to the VA canteen service found that a senior official used a Government vehicle to help his son deliver newspapers in their neighborhood. VA issued the official a reprimand for using the vehicle for other than official purposes.

### **Misuse of Government Equipment**

- A VHA review initiated by a Hotline inquiry found that a VAMC employee misused a Government computer and telephone on several occasions during her scheduled duty hours.

Management officials informed us they would take the appropriate disciplinary action.

### **Personnel Irregularities**

- A VHA review initiated by a Hotline inquiry of a kitchen operation substantiated significant of personnel policies by the supervisor and the staff. The Board of Investigations recommended disciplinary actions including the suspension of some employees.
- A Hotline inquiry prompted a Human Resources Management (HRM) evaluation of the personnel operations at one medical center, which resulted in the identification of serious systemic and regulatory problems in the facility’s HRM program. Recommendations for corrective actions were made and were acted on by VAMC management, to include taking action to correct an inappropriate promotion.

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

- A VHA review initiated by a Hotline inquiry substantiated that a VAMC surgical service employee failed to enter a request for two days of annual leave. It was also found that the employee was certifying his own timecard. Action was taken to correct the employee’s timecard to reflect annual leave taken for the two days in question and the employee was counseled for not recording leave for brief absences from duty and failure to record other annual leave. The service chief was also counseled for failing to ensure proper timekeeping procedures.

## Veterans Benefits Administration

### Falsification of Pension Information

A VBA review initiated by a Hotline inquiry found that a pension recipient who ran a homeless shelter falsified information on his pension application. The VARO assessed an overpayment of \$11,417 against the veteran. The VARO also noted that the veteran left the area after withdrawing \$15,528 in monies donated to the shelter. Hotline staff faxed materials to the regional counsel so state warrants could be issued for the veteran's arrest.

### Continuing Compensation Payments to Incarcerated Veterans

- A VBA review initiated by a Hotline inquiry found that a 100 percent service-connected veteran had been incarcerated since late November 1997 and had not been subjected to a reduction in benefits as prescribed by law. This created an overpayment in excess of \$18,000. The VARO took action to reduce the veteran's monthly compensation from \$2,110 to \$94.
- Another VBA review initiated by a Hotline inquiry found that a 100 percent service-connected veteran was incarcerated but continued to receive payments without a prescribed reduction in benefits as prescribed by law. This created an overpayment of \$1,652. The veteran's compensation benefits were reduced from \$2,078 to \$95 monthly.

### Fiduciary Use of Veteran's Funds and Purchasing Items

A VBA review initiated by a Hotline inquiry found that a veteran's fiduciary purchased computer equipment using the veteran's VA benefits money. The fiduciary will reimburse

the veteran's estate \$1,637. The VARO will continue to monitor this case closely to prevent further improprieties in administering the veteran's VA money.

### Claiming Dependents for VA Benefits

- A VBA review initiated by a Hotline inquiry found that a widow was reporting that her daughter was in school for countable income purposes, even though the daughter had discontinued school attendance and was working. The daughter was removed from the widow's benefits award, creating an overpayment of \$735. The VARO has taken action to recoup the amount of the overpayment.
- Another Hotline inquiry to VBA found that a veteran failed to notify VA that he was divorced and that he continued to claim his stepchildren on his award. An overpayment of \$4,287 was created.
- A VBA review initiated by a Hotline inquiry confirmed that a veteran's spouse continued to receive an apportionment of his benefits, although they were divorced. The veteran had provided a copy of the petition for divorce from his spouse but had not provided a copy of the final decree issued by the court. The VARO created an overpayment to recoup the amount of the apportionment after the divorce was final.

## B. SPECIAL INQUIRIES SECTION

The special inquiry reports discussed below address serious issues of misconduct against high ranking officials and other high profile matters, which received a great amount of interest from the U.S. Congress, Secretary, VA managers, media, and the general public.

## Veterans Health Administration

### Management, Clinical, and Administrative Issues

The OIG reviewed numerous allegations of mismanagement, misconduct, poor clinical care practices, criminal activity, and administrative irregularities at the VA Central Alabama Veterans Health Care System. While many of the allegations were not substantiated, we did substantiate that the Director improperly spent funds, misused his Government credit card, inappropriately attempted to use appropriated funds for an employee picnic, and impeded OIG efforts to investigate issues. The Director also engaged in questionable personnel practices.

We substantiated that the Associate Director submitted questionable claims for travel reimbursements and attempted to pressure subordinates to spend appropriated funds inappropriately. The Associate Director also violated nepotism laws and engaged in prohibited personnel practices by retaliating against one or more employees for whistleblowing. We substantiated that five former service chiefs were victims of harassment and/or retaliation. We also found that numerous personnel regulatory and procedural violations occurred at the facility. Our healthcare inspectors substantiated some allegations involving instances of inappropriate patient care. The inspectors also expressed concern over staffing nursing units, patients' nutritional care, and several other patient care issues. Healthcare inspectors found that managers needed to concentrate on improving certain quality management practices. We also noted administrative controls for monitoring time and attendance, Government credit cards, fire and safety, and Government property needed improvement.

The Chief Network Officer concurred, or partially concurred with 68 of the 74 recommendations made in the report. Of the remaining six responses, VHA deferred comment on two recommendations. We are following up on these issues until they are resolved. VHA did not concur with three of the five recommendations on behalf of employees whom we concluded were retaliated against by VA management. The employees have filed, or have been notified of their right to file, a complaint with the Office of Special Counsel. VHA also did not agree to take administrative action against the Director for engaging in prohibited personnel practices. We have referred this matter to the Deputy Secretary for resolution. (*Management, Clinical, and Administrative Issues at the VA Central Alabama Veterans Health Care System, 8PR-G03-144, September 29, 1998*)

### Procurement Issues and Violation of Spending Authority

A review substantiated that 6 of 12 contested procurements made at a facility violated Federal Acquisition Regulations. The review also found that facility senior officials and acquisition staff did not adequately resolve the procurement protests. The procurement staff also inappropriately obligated \$468,395 in funds after the legal spending authority had expired. VHA took appropriate administrative actions against the responsible officials, and corrected other identified deficiencies. (*Procurement Issues, VAMC Ann Arbor, Michigan, 8PR-E11-134, September 16, 1998*)

### Employees' Right to Report Complaints

The special inquiry review substantiated that a Director issued a memorandum prohibiting employees from reporting complaints to outside organizations without first reporting them internally. We found that the memorandum was contrary to the Inspector General Act of 1978



and the Whistleblower Protection Act of 1998, which preserve Federal Government employees' right to bring their concerns to the OIG, the Office of Special Counsel, and others without fear of reprisal. VHA took action to rescind the memorandum and issue one in compliance with the Whistleblower Protection Act of 1978. (*Employees' Right to Report Complaints, VAMC Albuquerque, New Mexico, 8PR-F03-119, July 22, 1998*)

### **Use of Official Position for Personal Gain**

A special inquiry review responded to allegations that a VA health care provider referred a patient to his private business. Conduct regulations prohibit employees from using their public office for private gain. The VHA took administrative action against the physician employee in this matter. (*Use of Official Position for Personal Gain, VAMC Iowa City, Iowa, 8PR-F03-115, June 30, 1998*)

### **Employee Conduct**

A special inquiry report responded to allegations that a supervisor and other staff exhibited conduct unbecoming Federal employees by hiring two female exotic dancers to perform in the nude at the VA facility. VHA informed us they would take administrative action against the responsible employees in this matter. (*Employee Conduct, VAMC Gainesville, Florida, 8PR-G03-110, June 3, 1998*)

### **Conduct, Personnel, and Contracting Issues**

A report responds to allegations that a Director misused his position, employees inappropriately received free meals and consumed alcohol at the facility, and other staff improperly contracted for certain services. The review substantiated the first two allegations. We did not substantiate that staff inappropriately contracted for services. VHA took appropriate administrative actions to

correct the other conditions noted in the report. (*Conduct, Personnel and Contracting Issues, James A Haley VAMC Tampa, Florida, 8PR-A19-095, May 4, 1998*)

### **Travel and Funds Management by a Former Official in VA Central Office**

A report responds to allegations that a senior quality management official inappropriately claimed and received reimbursement for unauthorized travel. VHA took administrative action and initiated collection procedures. (*Travel and Funds Management by a Former VHA Official in VA Central Office, 8PR-A19-096, April 20, 1998*)

## **Veterans Benefits Administration**

### **Relocation Expenses and Reimbursement Issues**

A review at a VARO substantiated an allegation that a supervisor improperly claimed and was reimbursed real estate expenses not incidental to a transfer to a new duty location. The report recommended that a debt be established to collect the real estate expenses, including all withholding tax and relocation income tax allowances improperly paid to the employee. A final accounting found that the debt was \$19,352. Action was taken to initiate the appropriate collection procedures. (*Relocation Expenses and Reimbursement Issues at VARO San Diego, California, 8PR-B01-097, April 17, 1998*)

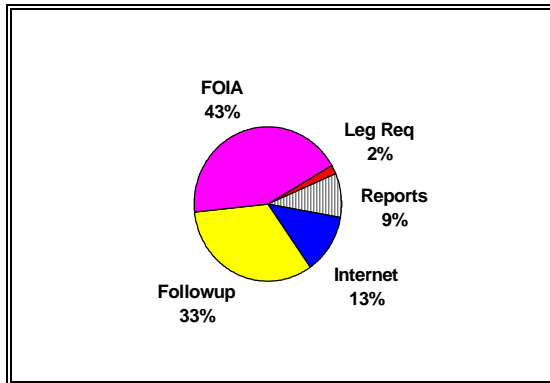
### III. POLICY, FOLLOWUP AND OPERATIONAL SUPPORT

#### Mission Statement

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

#### Resources

This Division has 9 FTE with the following allocation:



#### Overall Performance

##### Followup on OIG Reports

The Division is responsible for obtaining implementation actions on audits, inspections,

and reviews with over \$1 billion of actual or potential monetary benefits as of September 30, 1998. Of this amount \$795 million is resolved, but not yet realized as VA has agreed to implement the recommendations, but has not yet done so. In addition, \$248 million relates to unresolved reviews awaiting contract resolution by VA contracting officers.

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

Management officials are required to provide the OIG with documentation showing the completion of corrective actions, including reporting of collection actions until the amounts due VA are either collected or written off. OIG staff evaluates information submitted by management officials to assess both the adequacy and timeliness of actions and to request periodic updates on an ongoing basis.

As of September 30, 1998, VA had 116 open OIG reports with 293 unimplemented internal recommendations, 4 unresolved internal recommendations, and 57 unresolved contract review recommendations.

During this reporting period, the Division took action to close 75 reports issued in this and prior periods, with 242 recommendations and a monetary benefit of \$133 million, after obtaining information that showed management officials had fully implemented corrective actions.

During this period, 100 percent of followup requests on immediate actions were sent within three months. The previous standard was six months. Also, 100 percent of the initial and the subsequent followup letters were processed in less than 3 months, as compared with the former 7 month average.

### **FOIA, Privacy Act, and Other Disclosure Activities**

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

During this reporting period, we processed 134 requests under the Freedom of Information and Privacy Acts and released 208 audit, investigative, and other OIG reports. In eight instances we had no records. We totally denied two requests under the appropriate exemptions of the Acts. Information was partially withheld in 96 requests because release would have constituted an unwarranted invasion of personal privacy, interfered with enforcement proceedings, disclosed the identity of confidential sources, disclosed internal Department matters, or was specifically exempted from disclosure by statute.

During this period, 96 percent of FOIA cases received written responses within 20 working days, as compared with 86 percent previously. Also, the average processing time for workable FOIA requests was reduced from 32 days to 14 days.

### **Internet Technology**

The Division's OIG Webmaster is responsible for all electronic processing of OIG reports, including the maintenance of the OIG web sites and the posting of OIG reports on the Internet. The OIG's public web pages received 400,000 hits from over 26,000 visitors during this period.

During this period, we successfully responded to a blind FOIA requestor by electronically redacting a requested report, then converting it to the software format that the requestor preferred for her screen reader.

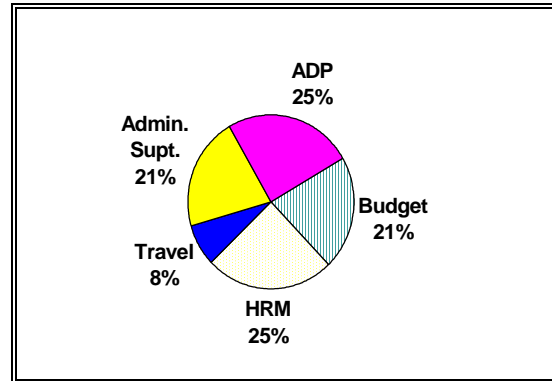
We initiated redesign and recoding of all OIG web pages to ensure that customers can quickly access the information they need and to ensure that vision-impaired veterans and other customers can access our web site.

We electronically redacted and converted 4 frequently-requested reports and posted them on the Internet in compliance with the new Electronic FOIA requirements. We also posted a number of unredacted reports, press releases, and all recurring OIG publications such as the last Semiannual Report to the Congress.

### **Review and Impact of Legislation and Regulations**

The Division coordinated concurrences on legislative and regulatory proposals from the Congress, Office of Management and Budget and the Department that relate to VA programs and operations. The OIG commented and made recommendations concerning the impact of the legislation and regulations on economy and

efficiency in the administration of programs and operations or the prevention and detection of fraud and abuse. During this period, 80 legislative, 50 regulatory proposals, and 11 “other” proposals were reviewed and 28 were commented on, as appropriate.



## IV. RESOURCES MANAGEMENT DIVISION

### Mission Statement

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

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

### Resources

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

### Overall Performance

#### Automated Data Processing

A system analysis was performed by a private contractor, which indicated that Resources Management must update both its hardware and basic operating system before it can begin to develop a management information system integrating operational and functional information (including a Master Case Index). A contract will be awarded in the first quarter of FY 1999.

#### Budget

In response to numerous Congressional requests for information concerning how we would utilize additional personnel resources, we provided details on how these positions would be allocated within the organization and the performance improvements that would accrue as a direct result.

The staff executed the 1998 budget within .001 percent of our authority.

#### Human Resources Management

During this period, the HRM staff brought on board 36 employees from 13 recruitment actions. Of these selections, 44% went to females and 17% to minorities.

The HRM staff also processed 82 personnel actions, 300 performance appraisals, 365 special contribution awards, 12 time-off awards, and 2 quality step increases.

### **Travel**

OIG personnel travel almost continuously. As a result, the Travel section processed 1,551 Vouchers as well as 6 Authorities for Permanent Change of Station.

### **Administrative Support**

An increase in the size of the Special Inquiries staff necessitated a relocation of this component. To accommodate the move, an office renovation was required. This involved substantial coordination between the OIG client and building management to ensure that construction was completed as designed, telephone lines were installed, and furniture and equipment were ordered, delivered, and set-up on schedule.

In addition, this section processed 114 procurement actions and reviewed and approved each month the 38 statements received by the OIG's cardholders under the Government's Purchase Card Program.

### **Customer Satisfaction Measures**

A Customer Satisfaction Survey form was developed and sent to all OIG Employees. The survey asked customers to rank services, ranging from 1 (poor) to 5 (excellent). Resources Management received an overall score of 4.0 in its initial survey.

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## OTHER SIGNIFICANT OIG ACTIVITY

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

#### **Investigation "Best Practices"**

The Chair, Investigations Committee, requested that a working group, comprised of Assistant Inspectors General for Investigations of those agencies represented on the committee, convene to discuss "best practices" in the IG community. The working group was convened in the wake of recent concerns voiced by several congressional oversight committees about the operations of some IG offices. In addition, because 1998 represents the twentieth anniversary of the IG Act, the chair thought that the time was right to examine the way in which the IG community conducts its investigations. The VA Assistant Inspector General (AIG) for Investigations was asked to chair the working group. The working group examined existing investigative polices, training issues, and the need for investigative oversight procedures. In addition, equipment for IG investigators was discussed. A report was submitted to the entire committee. On September 10, 1998, the committee concurred with the report recommendations and selected staff, from nominations submitted by PCIE/Executive Council on Integrity and Efficiency member agencies, for a newly established investigations advisory subcommittee. The new subcommittee will continue to examine "best practices" in the IG community and make recommendations to the investigations committee. The VA AIG for Investigations will chair the new subcommittee, which will also work with IG Academy staff to ensure that the best training possible is available to investigators in the community.

#### **Federal Audit Executive Council (FAEC)**

The AIG for Auditing was elected chairperson of the FAEC for 1998. The purpose of the

FAEC is to discuss and coordinate on issues affecting the Federal audit community in general and, in particular, matters affecting audit policy and operations of common interest to FAEC members. In addition, the AIG for Auditing is the Federal audit community representative on the PCIE audit committee.

#### **Inspections and Evaluation Roundtable**

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

#### **OIG Management Presentations**

##### **Presentation to VBA's Directors' Conference**

The Inspector General provided a presentation on OIG activities to VBA's Directors' Conference. In his remarks, the Inspector General expressed hope that the IG and VBA would continue to work closely to stem fraud against VBA.

##### **Presentation to Senate Committee Staffers on Automated Data Processing (ADP) Controls**

VA OIG audit staff met with the staff of the Senate Committee on Veterans Affairs concerning our review of ADP controls on the FY 1997 CFS audit. General Accounting Office (GAO) ADP auditors also met with the Committee staff. Our review found significant weaknesses, which made VA assets and financial data vulnerable to error or fraud.

**Association for Government Accountants (AGA)**

The AIG for Auditing participated on the AGA Board to review and award Certificate of Excellence in Accountability Reporting. He is also a member of VA's Chief Financial Officers Council.

**Presentation at PCIE Roundtable**

The AIG for Auditing and the Director, Kansas City Audit Operations Division, conducted a seminar on electronic workpapers to the PCIE Roundtable. The presentation discussed an electronic workpaper system developed by our office. A similar presentation was provided to the National Association of Local Government Auditors at their national professional development conference.

**Presentation at Information Security Officers' Conference**

VA OIG audit staff presented a briefing on OIG operations and information security issues identified by our audit work. The presentation highlighted key areas for VA focus.

**Participation in VHA's Year 2000 (Y2K) Conferences**

VA OIG audit staff participated in VHA's Y2K conference and was on a panel with Congressional staff. The project manager also discussed Y2K issues that had been identified as part of an ongoing OIG audit.

**Participation in Financial Statement Audit Work Groups**

During this reporting period, the OIG financial audit staff continued their participation in the Federal Audit Executive Council subgroup on financial statement audits and in the PCIE financial statement audit manual task force.

Both working groups are important in sharing information on areas of common interest with the objective of improving the Federal financial statement audit process.

**Kansas City Federal Executive Board**

The Director, Kansas City Audit Operations Division, conducted a seminar on "Fraud Detection" for the Greater Kansas City Federal Executive Board at their annual Best Practices Symposium.

**Presentation at a PCIE Training Symposium**

VA OIG audit staff presented a briefing on Information Technology contracting at a PCIE training symposium.

**Presentations at International Nursing Conference**

An Office of Healthcare Inspections Registered Nurse Health Systems Specialist made several presentations at an International Nursing Symposium in Costa Rica. Her presentations included such wide-ranging subjects as nursing oncology procedures, cancer prevention, and various aspects of breast cancer detection, prevention, and treatment.

**Presentation at the National Logistics Management Training Symposium**

The OIG Counselor and Director, Contract Review and Evaluation Division, gave a presentation on lessons learned from OIG audits. The conference was attended by all organizational elements of VA and by representatives from other government agencies.

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### **Coalition for Government Procurement Health Care Contracting Workshop**

An audit manager, Contract Review and Evaluation Division, presented a talk on “The Ins and Outs of Managing Pharmaceutical and Medical Equipment Schedules.” We provided information to industry representatives on the changes in the procurement regulations and the FSS contracting requirements. Specifically, the changes in disclosure requirements, the common difficulties we have experienced during preaward reviews, how we audit a contractor’s compliance with the price reduction clause, and requirements of the new postaward audit clause.

### **FSS Training Class, National Acquisition Center**

The Director, Contract Review and Evaluation Division gave a presentation on FSS preaward and postaward audits to a group of contracting officers and General Counsel attorneys at the National Acquisition Center. Both auditors and contracting officers benefit from sharing work-related experiences in these training sessions.

### **Presentation at the Johnson & Johnson Annual Government Contract Seminar**

An audit manager, Contract Review and Evaluation Division, made a presentation at the Johnson & Johnson Government Contract Seminar. Presentation topics included preaward and postaward audits, commercial selling practices, defective pricing, price reduction, and the OIG role in VA FSS contracting.

### **Participation in Paperless Auditing Conference**

We provided information on Electronic FOIA, electronic redactions, and electronic information management at the Conference on Paperless Auditing sponsored by PCIE's Federal Audit Executive Council.

### **OIG Congressional Testimony**

In May 1998, the Inspector General testified before the House Veterans’ Affairs Oversight and Investigations Subcommittee at a hearing on the results of a GAO report, “Veterans Affairs Special Inquiry Report was Misleading,” dated May 13, 1998. The testimony addressed the findings and conclusions of the GAO report on a 1995 Special Inquiry into a cover-up of an increase in deaths at a VA facility. While the Inspector General did not agree with the GAO on several issues, actions were taken to improve certain processes and procedures.

### **Obtaining Required Information or Assistance**

Sections 5(a)(5) and 6(b)(2) of the Inspector General Act of 1978 require the Inspector General to report instances where access to records or assistance requested was unreasonably refused, thus hindering the ability to conduct audits or investigations. During this 6-month period, there were no reportable instances under these sections of the Act.

Under P.L. 95-452, the IG has authority “... to require by subpoena the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence necessary . . . .” The use of IG subpoena authority has proven valuable in our efforts, especially in cases dealing with third parties. During this reporting period, 37 subpoenas were issued in conjunction with various OIG investigations, audits, and reviews.





# APPENDIX A

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
<b>INTERNAL AUDITS</b>				
8D2G07066 4/23/98	Audit of Security Controls for the Integrated Data Communications Utility			
8R3A01101 5/13/98	Audit of Cost-Per-Test Leases and Reagent Rental Contracts in Pathology and Laboratory Medicine Service	\$32,000,000	\$32,000,000	
8AFG10103 5/18/98	Report of Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 1997 and 1996			
8R5D02107 5/28/98	Audit of Adult Day Care/Clinics Construction Project at Department of Veterans Affairs Medical Center Asheville, NC	\$913,000	\$913,000	
8D2G01067 7/1/98	Audit of VA's Workers' Compensation Program Cost	\$246,931,574	\$246,931,574	
8R1G01118 7/10/98	Audit of the Medical Care Cost Recovery Program	\$83,223,496	\$83,223,496	
8R3G01123 7/14/98	Audit of the Government Travel Card Program			
8R5D02127 7/24/98	Audit of Nonrecurring Maintenance Construction Project at Department of Veterans Affairs Domiciliary White City, OR	\$243,300	* \$88,545	
8ANG01117 8/6/98	Audit of VHA Actions on Accounts Receivable	\$3,703,000	\$3,703,000	
8R5D02133 8/12/98	Audit of Energy Construction Project at Department of Veterans Affairs Medical Center Ann Arbor, MI	\$238,269	\$238,269	
8R5D02139 9/10/98	Audit of Pharmacy Renovation Project at Department of Veterans Affairs Medical Center San Francisco, CA	\$115,590	\$115,590	

\* Management disagreed with OIG estimate.

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

### **INTERNAL AUDITS (Con't)**

8R5B01147 9/22/98	Audit of Data Integrity for Veterans Claims Processing Performance Measures Used for Reports Required by the Government Performance and Results Act			
8R3A01149 9/30/98	Summary Report: Audits of Pathology and Laboratory Medicine Service	\$2,000,000	\$2,000,000	

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

8AFG10102 5/27/98	Accuracy of Property, Plant, and Equipment Financial Information			
8R1G10106 5/29/98	Management Letter, Fiscal Year 1997 Financial Statements, VA Life Insurance Programs and Selected Loan Guaranty Program Financial Activities			
8R8E11113 6/29/98	Evaluation of VA Freight and Household Goods Transportation Programs	\$1,277,000		* \$0
8R4G10128 7/29/98	Management Letter, Fiscal Year 1997 Consolidated Financial Statements – Veterans Benefits Administration Finance Center Hines, IL			
8R1B12130 7/31/98	Evaluation of the Life Insurance Programs' Administrative Expenses			
8AFG10140 9/10/98	Management Letter – Payroll Transactions			
8AFG10141 9/10/98	Management Letter – Expenditure Transactions			

### **SPECIAL INQUIRY**

8PRB01097 4/17/98	Alleged Improper Reimbursement of Relocation Expenses, Veterans Benefits Administration Regional Office, San Diego, CA			\$19,352
8PRA19096 4/20/98	Alleged Travel and Funds Management Irregularities by a Former VHA Quality Management Official			\$98
8PRA19095 5/4/98	Conduct, Personnel, and Contracting Issues at the James A. Haley VA Medical Center, Tampa, FL			\$104
8PRG03110 6/3/98	Alleged Misconduct by Employees at the VA Medical Center Gainesville, FL			

\* Management estimate will be provided at a later date.

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

### **SPECIAL INQUIRY (Con't)**

8PRF03115 6/30/98	Alleged Use of Official Position for Personal Gain, VA Medical Center Iowa City, IA			
8PRF03119 7/22/98	Alleged Interference With Employees' Right to Report Complaints VA Medical Center Albuquerque, NM			
8PRE11126 7/27/98	Furniture Purchases by Veterans Integrated Service Network 12, Hines, IL			
8PRE11134 9/16/98	Procurement Issues, VA Medical Center Ann Arbor, MI			
8PRG03144 9/29/98	Management, Clinical, and Administrative Issues at the VA Central Alabama Veterans Health Care System (CAVHCS)			\$8,828

### **HEALTHCARE INSPECTIONS**

8HIA28105 5/22/98	Demographic Descriptors of Veterans Health Administration's Acute Care Patient Population			
8HIA28111 6/2/98	Inspection of Alleged Medication System Problems Colmery-O'Neil VA Medical Center Topeka, KS			
8HIA28116 7/1/98	Inspection of Alleged Mistreatment of a Post- Traumatic Stress Disorder Patient Department of Veterans Affairs Medical Center Iowa City, IA			
8HIA28121 7/13/98	Inspection of Alleged Inappropriate Medical Care and Transfer of a Nursing Home Patient, Department of Veterans Affairs Medical Center Huntington, WV			
8HIA28122 7/13/98	Inspection of Selected Clinical Issues in a Patient's Care Department of Veterans Affairs Medical Center Atlanta, GA			
8HIA28124 7/14/98	Quality Program Assistance Review Program Oversight Review Report and Analysis			
8HIF03125 7/16/98	Inspection of Patient Care Allegations and Quality Program Assistance Review, Department of Veterans Affairs Medical Center Lyons, NJ			
8HIA28129 7/28/98	Inspection of Alleged Inappropriate Medical Care Department of Veterans Affairs Medical Center Tuskegee, AL			

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

### **HEALTHCARE INSPECTIONS (Con't)**

8HIA28132 8/13/98	Inspection of Alleged Inattentive and Inadequate Care for a Patient's Chest Pain, Department of Veterans Affairs Medical Centers Birmingham and Montgomery, AL			
8HIA28136 8/26/98	Inspection of Alleged Mistreatment of a Respite Care Patient, Department of Veterans Affairs Medical Center Atlanta, GA			
8HIA28137 9/1/98	Inspection of Allegations Pertaining to the Psychiatric Service, Department of Veterans Affairs Medical Center North Chicago, IL			
8HIF03145 9/17/98	Quality Program Assistance Review, Department of Veterans Affairs Medical Center Washington, DC			
8HIA28150 9/28/98	A Description and Analysis of the Office of Healthcare Inspections' Most Common Findings in Hotline Inspections: Fiscal Years 1993, 1994, and 1995			
8HIA28151 9/29/98	Suggested Supplementary Statistical Options for Monitoring Healthcare			
8HIA28152 9/30/98	Inspection of Alleged Mismanagement of Psychiatric Programs William Jennings Bryan Dorn Veterans' Hospital Columbia, SC			

### **CONTRACT REVIEWS \***

8PEE02086 4/3/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q4-97), Fuji Medical Systems U.S.A., Inc., Stamford, CT			
8PEE10094 4/6/98	Postaward Review of Federal Supply Schedule Contract V797P-3762j Fuji Medical Systems U.S.A., Inc., Stamford, CT			
8PEE02093 4/9/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97) a-Dec, Inc., Newberg, OR			

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
<b><u>CONTRACT REVIEWS (Con't)</u></b>				
8PEE02099 4/23/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97) Dentsply Trubyte, York, PA			
8PEE02098 5/1/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q4-97) Bayer Corporation, Agfa Division, Ridgefield Park, NJ	\$2,136,157		
8PEE02100 5/15/98	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Organon, Inc., West Orange, NJ	\$784,625		
8PEE02109 6/3/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97) Star Dental, Lancaster, PA	\$1,695,678		
8PED03112 6/24/98	Audit of Termination Settlement Proposal and Claims for Equitable Adjustment Submitted by Bar-Con Corporation Contract V523c-1129	\$333,886		
8PEE02114 6/24/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97) Kavo America Corporation, Lake Zurich, IL			
8PEA12104 7/1/98	Audit of Claim for Alleged Damages Under an Agreement with a VAMC	\$318,008		
8PEE02108 7/20/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q4-97) Imation Enterprises Corporation Oakdale, MN	\$9,340,040		
8PEX20135 9/4/98	Review of a Pharmaceutical Company's Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585			\$140,524
8PEX22138 9/10/98	Review of Prime Vendor Contractor Billings			\$9,392,565
8PEX14153 9/30/98	Federal Supply Schedule (FSS) V797P-3510j, Awarded to Diatek Instruments, Inc, San Diego, CA			\$1,980

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

**CONTRACT REVIEWS (Con't)**

8PEX06148 9/30/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97) Nobel Biocare USA, Inc., Westmont, IL	\$87,425		
8PEX12154 9/30/98	Post Award Audit of FSS Contract V797P-5947j, Boehringer Mannheim Corp., Indianapolis, IN			\$2,150,000
<b>TOTAL:</b>	<b>60 Reports</b>	<b>*\$385,341,048</b>	<b>\$369,213,474</b>	<b>\$11,713,451</b>

\* The difference between the OIG and Management estimates is \$16,127,574. The difference is explained as follows: Pending receipt of contracting officer's decision - \$14,695,819; Management disagreed with OIG estimate - \$154,755; Management estimate will be provided at a later date - \$1,277,000.

## APPENDIX B

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use	Unsupported Costs
8PEN03113 4/14/98	Proposal, RFP No. 626-18-98 Design/Construct Canopies, VAMC Nashville, Kiddway Corporation, Nashville, TN		
8PEN03119 7/1/98	Proposal, Contract No. V460c-310, Replace Fire Alarm & Sprinkler, VAMC Wilmington, R. I. Williams & Associates, Glenside, PA	\$4,476	
8PEN03117 7/21/98	Proposal, Contract No. V573p-3990, Transcription Serv., VAMC Gainesville, Precision Communications, Inc., Derry, NH,	\$106,975	
8PEN03123 7/29/98	Proposal, RFP No. 527-22-98, Install Sprinkler, VAMC Brooklyn, A & A Associates, Brooklyn, NY		
8PEN03127 7/30/98	Proposal, RFP No. 640-98-114, Roof Repair & Replacement, VAMC Palo Alto, Architectural Systems Corp., Sausalito, CA	\$29,162	
8PEN02005 8/6/98	Proposal, Project 508-018a, Clinical Addition, VAMC Atlanta, Caddell Construction Company, Montgomery, AL	\$17,565	
8PEN02006 8/6/98	Proposal, RFP No. D-35, Seismic/Modernation, VAMC Memphis, Cadde Construction Co., Memphis, TN		
8PEN03132 8/7/98	Proposal, RFP No. 584-46-98, Remodel Physical Therapy, VAMC Iowa City, Channel Construction Company, Omaha, NE		
8PEN03001 8/12/98	Proposal, RFP No. 600-0032-48, Payee Services, VAMC West Los Angeles, St. Joseph Center, Venice, CA		
8PEN02107 8/17/98	Proposal, Project No. 506-027b, Const. Pedestrian Bridge, VAMC Ann Arbor, Demaria Building Company, Inc., Novi, MI		
7PEN03137 9/1/98	Claim, Cont. V554c-755, Remodel Outpatient Clinic, VAMC Denver, Charles G. Williams Construction, Inc., Denver, CO	\$99,383	
7PEN02302 9/22/98	Claim, Project No. 501-051, Clinical Services Addition, VAMC Albuquerque, Centex Bateson Construction Co., Dallas, TX	\$658,517	
<b>TOTALS:</b>	<b>12 Reports</b>	<b>\$916,078</b>	

The Defense Contract Audit Agency (DCAA) completed all the reports issued. This data is also reported in the DoD OIG's Semiannual Report to Congress.





## APPENDIX C

### CONTRACT AUDIT REPORTS FOR WHICH A CONTRACTING OFFICER DECISION HAD NOT BEEN MADE FOR OVER 6 MONTHS AS OF SEPTEMBER 30, 1998

<u>Report Title, Number, and Issue Date</u>	<u>Questioned Costs</u>	<u>Recommended Better Use of Funds</u>	<u>Reason for Delay and Planned Date for a Decision</u>
<b>Contract Reviews by OIG</b>			
<b><u>OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT</u></b>			
Preaward Review of Federal Supply Schedule Proposal Submitted by Johnson and Johnson Healthcare Systems, Inc., Ethicon Inc., Piscataway NJ, 7PE-E12-088, 5/20/97		\$4,570,800	Pending receipt of Contracting Officer Price Negotiation Memorandum (PNM); No planned decision date available.
Preaward Review of Federal Supply Schedule Proposal Submitted by Johnson and Johnson Healthcare Systems, Inc., Ethicon Endo Surgery Inc., Piscataway, NJ, 7PE-E02-092, 6/6/97			Pending receipt of Contracting Officer PNM; No planned decision date available.
Preaward Review of Federal Supply Schedule Proposal Submitted by Johnson and Johnson Healthcare Systems, Johnson and Johnson Medical Inc., Piscataway, NJ, 7PE-E02-094, 7/11/97		\$10,806,808	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation No. M3-Q3-92) Johnson and Johnson Healthcare Systems Inc., Cordis Corporation and J&J Interventional Systems, Piscataway, NJ, 7PE-E12-107, 7/24/97		\$5,918,105	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) Wyeth-Ayerst Laboratories, Philadelphia, PA, 7PE-E02-127, 9/4/97		\$5,484,450	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97), Schein Pharmaceutical Inc., Florham Park, NJ, 7PE-E02-134, 9/17/97		\$2,718,799	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97), Bayer Corporation Pharmaceutical Division, West Haven, CT 7PE-E02-130, 9/23/97		\$3,580,134	Pending receipt of Contracting Officer PNM; No planned decision date available.

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

Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Roxane Laboratories, Inc., Columbus, OH, 8PE-E02-006, 10/2/97		\$3,684,555	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Alcon Laboratories, Inc., Forth Worth, TX, 8PE-E02-012, 10/8/97			Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Boehringer Ingelheim Pharmaceuticals, Inc., Ridgefield, CT, 8PE-E02-021, 10/16/97		\$7,893,240	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Schering Corporation, Union, NJ, 8PE-E02-024, 10/17/97		\$92,037,146	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Ortho Pharmaceutical Corporation, Raritan, NJ, 8PE-E02-015, 10/20/97		\$17,084,449	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Smithkline Beecham, Philadelphia, PA, 8PE-E02-029, 10/21/97		\$1,266,297	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Eli Lilly and Company, Indianapolis, IN, 8PE-E02-016, 10/22/97			Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Novartis Pharmaceuticals Corporation, East Hanover, NJ, 8PE-E02-026, 10/30/97		\$7,869,022	Pending receipt of Contracting Officer PNM; No planned decision date available.

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

Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Abbott Laboratories Hospital Products Division, Abbott Park, IL, 8PE-E02-038, 11/5/97		\$5,932,784	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97), Dentsply Caulk Milford, DE, 8PE-E02-055, 1/26/98			Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-92), Graphic Controls Corporation, Buffalo, NY, 8PE-E02-063, 1/26/98		\$294,535	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), McGaw Incorporated, Irvine, CA, 8PE-E02-064, 2/9/98		\$9,207,294	Pending receipt of Contracting PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97), Gendex Dental X-Ray, Division of Dentsply International, Inc., Des Plaines, IL, 8PE-E02-074, 3/4/98		\$91,969	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q4-97), Medrad, Inc, Indianola, PA, 8PE-E02-084, 3/19/98		\$2,468,847	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-92, Open Season IV) Howmedica, Inc., Pfizer Hospital Products Group Rutherford, NJ, 8PE-E02-081, 3/23/98		\$3,126,441	Pending receipt of Contracting Officer PNM; No planned decision date available.
Audit of Claims and Requests for Equitable Adjustments Submitted by Bay Construction Company, Contract Number V662C-1439, 8PE-E10-082, 3/25/98		\$394,154	Pending receipt of Contracting Officer PNM; No planned decision date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97), Midwest Dental Products Corporation (A Wholly Owned Subsidiary of Dentsply International, Inc.) Des Plaines, IL, 8PE-E02-089, 3/31/98			Pending receipt of Contracting Officer PNM; No planned decision date available.

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

**OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT**

Claim, Contract No. V554C-684, Laundry Chute VAMC Denver, CO, Hughes-Groesch Construction Co., Inc., Denver, CO, 7PE-N03-130, 3/31/97	\$450,977		Claim in litigation; no planned resolution date available.
Claim, Contract V101DC-0048, Expand/Renovate Bldg-1, VAMC Salt Lake, Interwest Construction Salt Lake City, UT, 7PE-N03-114, 9/30/97	\$1,469,934		Claim in appeal; planned resolution date not available.
Proposal, RFP 648-23-97, Radiation Oncology Services Oregon Health Sciences University Portland, OR, 7PE-N03-014, 12/1/97	\$17,850	\$127,920	Negotiation not finalized; no planned resolution date available.
Claim, Contract V554C-749, Enclosure for Patios, VAMC Denver, Charles G. Williams Construction, Inc., 7PE-N03-136, 1/23/98	\$48,502		Negotiation not finalized; no planned resolution date available.
Proposal, Project No. 543-015, Sprinkler & Fire Alarm Pro, VAMC Columbia Fire Security Systems, Inc., Bossier City, LA, 8PE-N03-110, 3/19/98	\$503,356		Negotiation not finalized; no planned resolution date available.

**OFFICE OF FACILITIES MANAGEMENT**

Change OR/FR 10 Contract No. V101BC0053 VAMC Atlanta, GA Caddell Contraction Masterclean, Incorporated, Decatur, GA, 3PE-N02-111, 11/16/93	\$126,130		Negotiation not finalized; resolution planned for next reporting period.
Adjustment Claim, V101C-1606, Construction Service, VAMC Albany, Bhandari Constructors Inc., Syracuse, NY, 5PE-N02-007, 3/31/95	\$271,599		Negotiation not finalized; no planned resolution date available.
Claim, Contract No. V101C-1651, Environment Improvement, VAMC North Chicago, Blount Inc. 4PE-N02-202, 2/7/96	\$7,370,861		Negotiation not finalized; no planned resolution date available.
Claim, Contract V101C-1532, Asbestos Removal VAMC W. Roxbury, Saturn Construction Co., Inc., Valhalla, NY, 5PE-N02-006, 2/23/96	\$875,708	\$1,898	Negotiation not finalized; resolution planned for next reporting period.

<u>Report Title, Number, and Issue Date</u>	<u>Recommended Better Use of Funds</u>	<u>Unsupported Costs</u>	<u>Reason for Delay and Planned Date for a Decision</u>
<b><u>OFFICE OF FACILITIES MANAGEMENT (Con't)</u></b>			
Claim, Project No. 632-062, 120 Bed Nursing Home Care Unit, VAMC Northport, J.F. O'Healy Construction Corporation, Bayport, NY, 3PE-N02-001, 3/26/96	\$1,623,126		Negotiation not finalized; resolution planned for next reporting period.
Claim, Contract V101BC0036; Defect. Drawings VAMC Palm Beach County, FL, Clark Construction Group, Inc., Hollywood, FL 6PE-N02-106, 11/6/96	\$3,363,356		Negotiation not finalized; no planned resolution date available.
Claim, Project No. 553-808, Replacement Hospital, VAMC Detroit, MI, Bateson/Dailey, Dallas, TX, 6PE-N02-204, 12/11/96	\$11,952,726		Negotiation not finalized; no planned resolution date available.
Claim, Contract No. V101C-1603, Install Sprinklers, VAMC Boston, L. Addison & Associates, Inc., Wakefield, MA, 6PE-N02-108, 12/19/96	\$1,120,170		Negotiation not finalized; no planned resolution date available.
Claim, Project No. 690-035 MFI Addition, VAMC Brockton, Saturn Construction Co., Inc., Valhalla NY, 6PE-N02-001, 5/19/97	\$724,755		Negotiation not finalized; no planned resolution date available.
Proposal, Project No. 672-045, Change Order Outpatient Clinic Add., VAMC San Juan, J.A. Jones Construction Co., San Juan, PR, 7PE-N02-007, 12/9/97	\$284,827		Negotiation not finalized; no planned resolution date available.

**OFFICE OF THE GENERAL COUNSEL**

Claim, Contract No. V539C-591, Install Incinerator, VAMC Cincinnati R.E. Schweitzer Construction, Cincinnati, OH 4PE-N03-113, 6/21/94	\$131,932		Contract in litigation; no planned resolution date available.
Claim, Contract No. V657C-1103; Replace HVAC VAMC St. Louis, Gross Mechanical Contractors Inc., St. Louis, MO, 6PE-N03-119, 10/24/96	\$90,437		Claim in litigation; no planned resolution date available.
Proposal, Project No. 549-085, Clinical Addition, VAMC Dallas, Centex Construction Company, Inc., Dallas, TX, 7PE-N02-303, 5/20/97	\$14,804,392		Claim in litigation; no planned resolution date available.

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

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

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

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

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

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## APPENDIX D

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### FOLLOWUP/RESOLUTION OF OIG RECOMMENDATIONS

The Inspector General Act Amendments of 1988 require identification of all significant management decisions with which the Inspector General is in disagreement and all significant and other recommendations unresolved for over 6 months (management decisions not made). We had no Inspector General disagreements on significant management decisions and there were no internal audit recommendations unresolved for over 6 months as of September 30, 1998. Contract report recommendations unresolved for over 6 months are included in Appendix C.

Following are tables which provide a summary of the number of OIG reports with potential monetary benefits that were unresolved at the beginning of the period, the number of reports issued and resolved during the period with potential monetary benefits, and the number of reports that remained unresolved at the end of the period.

### SUMMARY OF UNRESOLVED AND RESOLVED OIG AUDITS

As required by the IG Act Amendments, Tables 1 and 3 provide statistical summaries of unresolved and resolved audit reports for the period April 1, 1998 – September 30, 1998. The dollar figures used throughout this report are based on the definitions included in the IG Act Amendments of 1988. The figures are current as of September 30, 1998, and may reflect changes from the data in the individual reports due to OIG validation to ensure compliance with the IG Act Amendments definitions.

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

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

MONTHS	TYPE AUDIT	NUMBER	TOTAL
Over 6 Months	Internal Audit	0	44
	Contract Audit	44	
Less Than 6 Months	Internal Audit	1	16
	Contract Audit	15	
<b>TOTAL</b>			<b>60</b>

Tables 2 and 3 show a total of 49 reports that were unresolved as of September 30, 1998. This number differs from the 60 reports shown above because tables 2 and 3 include only reports with monetary benefits as required by the IG Act Amendments. Tables 2 and 3 also provide the reports resolved during the period with the OIG estimates of disallowed costs and funds to be put to better use, including those in which management agreed to implement OIG recommendations and those in which management did not agree to implement OIG recommendations. The Assistant Secretary for Management maintains data on the agreed upon reports and Management estimates of disallowed costs and funds to be put to better use in order to comply with the reporting requirements for the Secretary's Management Report to Congress, required by the IG Act Amendments.



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

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

<b>RESOLUTION STATUS</b>	<b>NUMBER OF REPORTS</b>	<b>QUESTIONED COSTS (In Millions)</b>
No management decision by 3/31/98	3	\$ 5.5
Issued during reporting period	8	\$ 11.7
<b>Total Inventory This Period</b>	<b>11</b>	<b>\$ 17.2<sup>1</sup></b>
Management decision during reporting period		
Disallowed costs	11	\$ 16.0
Allowed costs	0	\$ 0
<b>Total Management Decisions This Period</b>	<b>11</b>	<b>\$ 16.0<sup>1</sup></b>
<b>Total Carried Over to Next Period</b>	<b>0</b>	<b>\$ 0<sup>1</sup></b>

<sup>1</sup> The total inventory this period amount (\$17.2 million) minus the total management decision this period amount (\$16.0 million) does not equal the carryover amount (\$0) because of a \$1.2 million questioned cost decrease during the period on a report issued in a prior period.

**Definitions:**

- **Questioned Costs**

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

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

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

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

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

<b>RESOLUTION STATUS</b>	<b>NUMBER OF REPORTS</b>	<b>RECOMMENDED FUNDS TO BE PUT TO BETTER USE (In Millions)</b>
No management decision by 3/31/98	65	\$319.8
Issued during reporting period	23	\$386.2
<b>Total Inventory This Period</b>	<b>88</b>	<b>\$706.0</b>
Management decisions during reporting period		
Agreed to by management	22	\$404.5
Not agreed to by management	17	\$30.7
<b>Total Management Decisions This Period</b>	<b>39</b>	<b>\$435.2</b>
<b>Total Carried Over to Next Period</b>	<b>49<sup>1</sup></b>	<b>\$245.4<sup>2</sup></b>

<sup>1</sup> Of the 49 reports carried over, a management decision had not been made for over 6 months on 37 reports with a dollar value of \$229.5 million.

<sup>2</sup> The total inventory minus the total management decision does not equal the total carried over, due to a net decrease of Funds Put to Better Use amounting to \$25.4 million.

**Definitions:**

- **Recommended Better Use of Funds**

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

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

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

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



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## APPENDIX E

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### REPORTING REQUIREMENTS OF THE INSPECTOR GENERAL

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

<b><u>IG Act References</u></b>	<b><u>Reporting Requirement</u></b>	<b><u>Page</u></b>
Section 4 (a) (2)	Review of legislation and regulations	58
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-60
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-60
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	79
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	63
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	65-71 (App. A & B)
Section 5 (a) (7)	Summary of each particularly significant report	i to v
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	80 (Table 2)
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	81 (Table 3)
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	73 to 78 (App. C)
Section 5 (a) (11)	Significant revised management decisions	None
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	None



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## APPENDIX F

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### VA FIELD OPERATIONS

#### Investigations

Northeast Field Office (51NY) New York, NY .....	212 807-3444
Boston Resident Agency (51BN) Boston, MA .....	781 687-3138
Newark Resident Agency (51NJ) Newark, NJ.....	973 645-3590
Washington, DC Resident Agency (51WA) Washington, DC .....	202 565-8079
Southeast Field Office (51SP) Bay Pines, FL .....	727 398-9559
Atlanta Resident Agency (51AT) Atlanta, GA .....	404 347-7869
Columbia Resident Agency (51CS) Columbia, SC .....	803 695-6707
New Orleans Resident Agency (51NO) New Orleans, LA .....	504 619-4340
West Palm Beach Resident Agency (51WP) West Palm Beach, FL.....	561 882-7720
Western Field Office (51LA) Los Angeles, CA .....	310 268-4268
Phoenix Resident Agency (51PX) Phoenix, AZ .....	602 640-4684
San Francisco Resident Agency (51SF) Oakland, CA.....	510 637-1074
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